

When the Helping Hand Hurts: How Medical Child Abuse Charges Are Undermining Parents' Decision-Making Rights over Children's Medical Care

by
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More than forty years ago, in the pages of the *Yale Law Journal*, Joseph Goldstein, one of the leading scholars in the field of American family law,² cautioned against the misuse of “the vague and subjective language of neglect and abuse statutes” to “give the state unguided discretion to supervene parental decisions with regard to health care for their children.”³ Professor Goldstein warned that such statutes could be misconstrued to “release[] the rescue fantasies of those it empowers to intrude” – those “well-intentioned people who ‘know’ what is ‘best’ and who wish to impose their personal health-care preferences on others.”⁴ Professor Goldstein’s comments presciently describe the recent rise of so-called “medical child abuse” (MCA) charges now being leveled against parents by doctors. Proponents of this new “diagnosis”—mainly pediatricians who specialize in child abuse—argue that parents who seek medical care that a doctor deems unnecessary have committed abuse, and doctors should “diagnose” this abuse and report it to child protection authorities.

Unfortunately, the definition of MCA developed by its proponents, as well as the process that they use to determine

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² See JOSEPH GOLDSTEIN, ANNA FREUD, & ALFRED J. SOLNIT, *BEYOND THE BEST INTERESTS OF THE CHILD* (1973).

³ Joseph Goldstein, *Medical Care of the Child at Risk: On State Supervision of Parental Autonomy*, 86 *YALE L.J.* 645, 650-51 (1977).

⁴ *Id.* at 651.

whether MCA has occurred, are so broad and vague that they allow pediatricians virtually unchecked discretion to target almost any medical care received by children as abusive. The fact that the child is legitimately sick or that the parent has sought medical care in good faith does not exclude an MCA “diagnosis.” Neither does the fact that a specialist ordered the challenged care, and often still believes it is necessary. The result is that increasing numbers of parents, particularly those with children who have complex or hard to diagnose medical issues, are being reported for child abuse. Once a report of suspected abuse is made, child protection officials and courts generally accept an MCA “diagnosis” as demonstrating child abuse,⁵ despite the fact that MCA’s broad definition and vague diagnostic criteria allow pediatricians to target a far broader array of behavior than that which constitutes legal abuse. The result is that, when a health crisis arises, many parents with sick children, particularly those with complex medical conditions, are fighting in court to retain custody rather than making medical decisions in their children’s best interest.⁶ In a rare but rising number of cases, states also prosecute these abuse charges criminally, so that parents must also fight to avoid prison.⁷ Meanwhile their children are sometimes left in the hospital alone,⁸ sometimes forced into foster care,⁹ and

⁵ See Neil Swidey & Patricia Wen, *A Medical Collision with a Child in the Middle*, BOS. GLOBE (Dec. 15, 2013), <https://www.bostonglobe.com/metro/2013/12/15/justina/vnwzbbNdiodSD7WDTh6xZI/story.html>.

⁶ See, e.g., the account of Justina Pelletier, *infra* notes 11-14 and accompanying text.

⁷ For example, in 2015, Katie Ripstra was sentenced to two twenty-year sentences in prison by a Texas court for MCA on the testimony of doctors that the mother had induced symptoms in her child through poisoning with salt, over the testimony of two physicians — one a nationally-recognized mitochondrial disease specialist — that her daughter suffered from mitochondrial disease. See Meagan Flynn, *Jury Finds Former Nurse Guilty of Salt Poisoning Daughter*, HOUS. PRESS (Sept. 25, 2015, 5:30 PM), <http://www.houstonpress.com/news/jury-finds-former-nurse-guilty-of-salt-poisoningdaughter-7794723>. During this period, Katherine Parker was also charged criminally with MCA in Oregon for caring for her sick children. See Meg Wagner, *Oregon Mom Accused of Subjecting Three Kids to Unnecessary Surgery, Heavily Drugging Them Gets Probation*, N.Y. DAILY NEWS (Feb. 24, 2016), <https://www.nydailynews.com/news/national/ore-mom-accused-medical-child-abuse-probation-article-1.2542517>.

⁸ This was the case for Justina Pelletier, whose parents were allowed to visit for an hour a week. See Neil Swidey & Patricia Wen, *Frustration on All*

often required to forgo medical treatment ordered by their own medical specialists and determined by their parents to be in their best interests.¹⁰

One of the first widely publicized MCA cases was that of Justina Pelletier. In February 2013, fourteen-year old Justina was admitted to Boston Children's Hospital (BCH) for gastrointestinal issues.¹¹ At that time, Justina was being treated by a well-respected Tufts University medical team for mitochondrial disease, a genetic disease that affects energy production, and which can cause gastrointestinal problems. The Tufts team had recommended to her parents that she be admitted to BCH because her long-time gastroenterologist had recently transferred there. That gastroenterologist never got the chance to treat her, however. Without consulting the Tufts doctors, BCH doctors, led by a neurologist just months out of medical training, swiftly decided that Justina did not have mitochondrial disease, an illness with complex, sometimes disputed, diagnostic criteria. Instead, BCH declared her issues psychiatric in nature, and prescribed in-patient psychiatric care.¹²

Faced by that conflict in physicians' medical opinions, Justina's parents should have been able to exercise their right as parents to decide between the two courses of treatment. However, when they asked BCH to transfer Justina to Tufts Hospital

Fronts in Struggle over Child's Future, BOSTON GLOBE (Dec. 16, 2013), <https://www.bostonglobe.com/metro/2013/12/16/month-medical-ordeal-conclusion-still-uncertain/Y7qvYTGsq8QklkxUZvuUgP/story.html>.

⁹ This was the case for teenager Isaiah Rider, who spent four months in foster care in Illinois after doctors at the Ann & Robert H. Lurie Children's Hospital in Chicago reported his mother for MCA. The report occurred during Isaiah's recovery from surgery to remove a tumor, when his mother considered transferring him to another hospital because she believed his pain was not being adequately managed. See Eric Adler, *Teen at Center of Medical Abuse Legal Wrangle Returns to KC, but Not to His Mom*, K. C. STAR (Sept. 20, 2014, 5:49 PM), <http://www.kansascity.com/news/local/article2184051.html>; see also Swidey & Wen, *supra* note 5 (describing Mannie Taimuty-Loomis and her husband losing custody of their three children for nine months before being cleared of MCA charges).

¹⁰ See, e.g., Swidey & Wen, *supra* note 5 (describing several cases in which Boston Children's Hospital interfered with treatment ordered by specialists and accepted by parents).

¹¹ *Id.*; Swidey & Wen, *supra* note 8.

¹² Swidey & Wen, *supra* note 5.

because they were convinced that her issues were physical not psychiatric, the BCH child protection team “diagnosed” Justina with MCA and reported suspected abuse to child protection officials. Seeking mitochondrial disease treatment for Justina, BCH asserted, subjected the child to unnecessary medical care, and was therefore abusive. Over the objections of Justina’s mitochondrial disease specialist at Tufts, both child protection officials and the dependency court judge deferred to BCH’s expertise in diagnosing MCA, and Justina’s parents lost custody and the right to determine their child’s medical care.¹³ After more than sixteen months and two birthdays out of her parents’ custody, much of it in BCH’s locked psychiatric ward where she was allowed to see her parents just one hour a week, Justina was finally returned to her parents in June 2014, sicker than when she entered.¹⁴

The Pelletier case was far from the only claim of MCA that BCH was pursuing at the time. In the 18-month period surrounding Justina’s MCA charges, BCH was involved in at least four other cases in which a disputed medical diagnosis led either to the parents losing custody or being threatened with losing custody.¹⁵ At about the same time as Justina’s admission, a five-year-old girl who had been treated for a mitochondrial disorder at Massachusetts General was admitted to BCH. A few weeks later, her mother was escorted out of the hospital by security guards and the state took custody of the child, leaving the five-year-old without a family member by her bedside at the hospital. In two other cases, children diagnosed elsewhere with PANDAS (Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections), an autoimmune diagnosis accepted by some doctors but not others, and for which evidence is equivocal, were deemed victims of MCA on their admission to

¹³ *Id.*

¹⁴ Neil Swidey & Patricia Wen, *Justina Pelletier Heads Home After Judge Ends State Custody*, BOSTON GLOBE (June 17, 2014), <http://www.bostonglobe.com/metro/2014/06/17/judge-orders-custody-justina-pelletier-returned-parents/mDWtuGURNawSuObO0pDX4J/story.html#>; see also Joshua Rhett Miller, ‘Awesome!’ Justina Pelletier Shouts on Way Home to Family After 16-Month Ordeal, FOX NEWS (June 18, 2014), <https://www.foxnews.com/politics/awesome-justina-pelletier-shouts-on-way-home-to-family-after-16-month-ordeal> (quoting Justina Pelletier’s mother: “[a]nd hopefully she’ll walk again — I’m not sure.”).

¹⁵ See Swidey & Wen, *supra* note 5.

BCH. In one of these cases, a teenager was placed in a locked psychiatric ward and custody was removed from her parents for seven months. In still another case involving a disputed diagnosis, after child protection officials refused to remove the child from his parents, the BCH child abuse team continued to pursue allegations of child abuse against the parents even after the child was moved to another hospital.¹⁶

Similar charges are being filed by pediatric teams at hospitals across the country. In fact, charging parents with MCA has become such a recognized practice among pediatricians who specialize in child abuse that, according to the former child abuse pediatrician (“CAP”) from BCH, they have given it a name: they call it a “parent-ectomy.”¹⁷ It is not possible to get a firm count on how many U.S. parents are being reported for MCA to child protection officials. Most states lump such charges into their general child abuse or neglect statistics, and cannot break out MCA charges separately. Michigan is the exception. Its figures show that, on average, fifty-one reports of suspected MCA were made against caregivers each year.¹⁸ If this rate is extrapolated to the general U.S. population, more than 1,600 U.S. parents are being reported each year.¹⁹ And the rates appear to be rising.²⁰

Probably far more parents are informally accused of MCA behavior and coerced into reversing their chosen course of medical care in order to avoid such reports being made.²¹ One Boston

¹⁶ See *id.*

¹⁷ See *id.*

¹⁸ Maxine Eichner, *The New Child Abuse Panic*, N.Y. TIMES (July 11, 2015), <https://www.nytimes.com/2015/07/12/opinion/sunday/the-new-child-abuse-panic.html>; Email from Kelcy McArthur, Analyst, Children’s Protective Services, Mich. Dep’t Hum. Servs., to author (Jan. 5, 2015, 11:03:38 EST) (on file with author) (figures are for the years between 2010 and 2013).

¹⁹ Eichner, *supra* note 18.

²⁰ This is based upon an estimate of reported medical child abuse cases between the years of 1999 and 2019. The first year in which the term “medical child abuse” was alleged in a court proceeding was in 1999. Throughout the early 2000s, there were only one or two medical child abuse cases per year. Since 2013, there has been a significant shift upward in the number of cases alleging medical child abuse against parents.

²¹ MitoAction, a patient advocacy nonprofit for families with mitochondrial disease, which has been contacted by more than 100 parents with concerns about MCA, reports that most of the parents facing allegations of medical child abuse accede to at least some changes in their child’s medical care in an effort

attorney who represents parents reports that two local hospitals have a practice of presenting parents with a detailed treatment plan if the parents disagree with doctors at the hospital regarding their child's course of care. The attorney had spoken to six parents who reported being told that if they refused to sign a consent form adopting the hospital's treatment plan they would be reported to the Massachusetts Department of Children and Families for MCA, their parental rights would be terminated, and that the court-appointed guardian would consent to the treatment plan anyway. According to the lawyer:

Each family remembered being told in no uncertain terms that “there is no point in fighting this. We always win.” or some strikingly similar iteration thereof. In each case, the hospital was true to its word: when the parents consented, the hospitals did not report abuse; when consent was withheld, the hospital's Child-Protection Team filed a report of suspected abuse or neglect immediately, the hospital did win in court, and the guardian did implement the treatment plan anyway.²²

Advocacy groups for families with rare diseases report a stark rise in MCA allegations being brought against parents of sick children during the last decade, despite the fact that the children had suspected or confirmed diagnoses of these diseases. MitoAction, which serves families with mitochondrial disease, formed a task force on Medical Child Abuse after receiving more than 100 reports from parents asserted to have committed MCA.²³ Advocacy organizations for families of other rare disorders also report a sharp increase in such allegations—including eosinophilic disorders (disorders relating to elevated numbers of certain white blood cells), Ehlers-Danlos Syndrome (a connective tissue disorder), and dysautonomia (an autonomic nervous system disorder).²⁴ These charges are occurring across the country.²⁵

to avoid MCA charges. Email from MaryBeth Hollinger, Nurse, Education, Support, and Advocacy Navigator, MitoAction, to author (Oct. 4, 2016, 12:33 EST) (on file with author).

²² Telephone Interview with John Martin, KJC Law Firm (Sept. 28, 2016).

²³ Email from Christine Cox, Director of Outreach & Advocacy, MitoAction to author (Feb. 5, 2015, 5:51 EST) (on file with author). This author first became acquainted with the issue of MCA when she was invited to join this task force. *See also* Eichner, *supra* note 18.

²⁴ *See* Eichner, *supra* note 18.

²⁵ *See id.*

This article argues that medical child abuse charges, as conceptualized and weaponized against parents, constitute a gross and devastating infringement on parents' constitutional right to determine their children's medical care.²⁶ Part I describes the recent origin of MCA charges. Part II shows that the broad definition of MCA adopted by physicians constitutes a vast, unprecedented, and unconstitutional expansion of the state's power to supervene and supervise parents' medical decision-making. Part III contends that the process through which physicians identify cases of MCA further expands its unconstitutional reach, and particularly targets parents of children with rare or complex health conditions. Part IV suggests that the untrammelled authority courts are allowing physicians in MCA cases may be influencing courts to expand physicians' authority beyond their proper bounds in medical neglect cases, as well. Finally, Part V suggests legislative reforms and litigation strategies that protect against these audacious incursions on parents' constitutional rights.

The Rise of Medical Child Abuse Charges

A. *From Munchausen's Syndrome by Proxy to Medical Child Abuse*

The precursor to the MCA movement dates back to 1977, when British pediatrician Roy Meadow published case studies of two mothers, each of whom had repeatedly sought medical care for their child but, according to Meadow, turned out to be deliberately making them ill, perhaps to earn sympathy from the child's physicians.²⁷ In one of the cases, the child ultimately died. Both mothers, Meadow noted, "were very pleasant people to

²⁶ I criticized the rising phenomenon of medical child abuse charges in a 2015 *New York Times* op-ed, in part based on my experience as the parent of a child with complicated medical issues, see Eichner, *supra* note 18, and provided a detailed explication of the legal, medical, and scientific problems with these charges in Maxine Eichner, *Bad Medicine: Parents, The State, and the Charge of "Medical Child Abuse,"* 50 U.C. DAVIS L. REV. 205 (2016) [hereinafter Eichner, *Bad Medicine*]. The current article expands on these earlier pieces and is addressed to lawyers defending parents against these charges.

²⁷ See Roy Meadow, *Munchausen Syndrome by Proxy: The Hinterland of Child Abuse,* 310 LANCET 343, 343-45 (1977).

deal with, cooperative, and appreciative of good medical care.”²⁸ Noting that the behavior resembled Munchausen Syndrome, the psychological syndrome in which healthy patients feign illness to obtain medical care, Meadow suggested that the phenomenon might be called “Munchausen [S]yndrome [B]y [P]roxy” (MSBP).²⁹ The name stuck. Beginning in the 1980s, doctors on both sides of the Atlantic began to diagnose cases of MSBP.³⁰

However, the conceptualization of this behavior as MSBP soon proved problematic for several reasons. First, while there was no doubt that the behavior constituted child abuse, debate arose regarding whether MSBP truly constituted a diagnosable psychological disorder;³¹ Meadow had not intended to assert that it did when he likened the behavior to Munchausen’s Syndrome.³² Controversy also arose over the limits of the conduct that constituted MSBP (must the parent’s motive be to assume the sick role by proxy?),³³ over whether to assign the MSBP diag-

²⁸ *Id.* at 344.

²⁹ *Id.* at 345.

³⁰ See generally Margaret Talbot, *The Bad Mother*, *NEW YORKER*, Aug. 9, 2004, at 62, 62-68 (discussing the history of MSBP charges).

³¹ Compare, e.g., Herbert A. Schreier & Judith A. Libow, *Munchausen Syndrome by Proxy: Diagnosis and Prevalence*, 63 *AM. J. ORTHOPSYCHIATRY* 318, 318 (1993) (treating MSBP as a psychological diagnosis), with Geoffrey C. Fisher & Ian Mitchell, *Is Munchausen Syndrome by Proxy Really a Syndrome?*, 72 *ARCHIVES DISEASE CHILDHOOD* 530, 532 (1995) (“The word diagnosis is usually understood as the identification or inferring of the presence of a disease by means of the patient’s symptoms,” yet no underlying psychological disease process had been identified in mothers identified with MSBP.). See generally ERIC MART, *MUNCHAUSEN’S SYNDROME BY PROXY RECONSIDERED* (2002) (describing numerous conceptual and evidentiary problems with MSBP); THOMAS A. ROESLER & CAROLE JENNY, *MEDICAL CHILD ABUSE: BEYOND MUNCHAUSEN SYNDROME BY PROXY* 17-35 (2008) (describing problems with MSBP diagnosis).

³² Roy Meadow, *What Is, and What Is Not, ‘Munchausen Syndrome by Proxy?’*, 72 *ARCHIVES DISEASE CHILDHOOD* 534, 535 (1995) (“In the past I have resented being asked in court whether someone is ‘suffering from Munchausen syndrome by proxy’: it has seemed no more appropriate than being asked if a man who has buggered his stepson is ‘suffering from sex abuse.’”).

³³ Compare, e.g., Meadow, *supra* note 27, at 345 (suggesting in his original paper that the mothers described seemed to “us[e] the children to get themselves into the sheltered environment of a children’s ward surrounded by friendly staff.”), and Herbert Schreier, *Munchausen by Proxy Defined*, 110 *PEDIATRICS* 985, 985 (2002) (“The primary motivation seems to be an intense need

nosis to the parent or the child,³⁴ and over whether the diagnosis should properly be made by a mental health specialist or a pediatrician.³⁵ Finally, and most consequentially, the criteria used to diagnose MSBP were never tested empirically for accuracy and turned out to falsely identify some parents of genuinely sick children.³⁶ In England, MSBP diagnoses were generally called into doubt and an official legal inquiry was opened after a number of mothers' criminal convictions were reversed because of expert pediatric diagnoses of MSBP that proved incorrect, not to mention grossly deficient in scientific rigor. These included at least five cases in which Dr. Meadow had testified as an expert witness against mothers being tried for the murder of their children,

for attention from, and manipulation of, powerful professionals, most frequently, but not exclusively a physician.”), with Donna Rosenberg, *From Lying to Homicide: The Spectrum of Munchausen Syndrome by Proxy*, in MUNCHAUSEN SYNDROME BY PROXY: ISSUES IN DIAGNOSIS AND TREATMENT 34 (Alex V. Levin & Mary S. Sheridan eds. 1995) (perpetrator's intent “diagnostically immaterial”), and Donna A. Rosenberg, *Web of Deceit: A Literature Review of Munchausen Syndrome by Proxy*, 11 CHILD ABUSE & NEGLECT 547, 547-63 (1987) [hereinafter Rosenberg, *Web of Deceit*] (perpetrator's motivation excluded from diagnostic criteria).

³⁴ Compare Meadow, *supra* note 32, at 535 (assigning diagnosis to child), with Donna A. Rosenberg, *Munchausen Syndrome by Proxy: Medical Diagnostic Criteria*, 27 CHILD ABUSE & NEGLECT 421, 423 (2003) (“MSBP is a pediatric, not a psychiatric, diagnosis”), with Schreier & Libow, *supra* note 31, at 318 (assigning the diagnosis to a parent). A special task force of the American Professional Society on the Abuse of Children sought to split the difference, dividing the diagnosis into two parts: “factitious disorder by proxy,” properly assigned to the perpetrator, and “pediatric condition falsification,” to be assigned to the child. See Catherine C. Ayoub et al., *Position Paper: Definitional Issues in Munchausen by Proxy*, 7 CHILD MALTREATMENT 105, 105-06 (2002).

³⁵ See Loren Pankratz, *Persistent Problems with the “Munchausen Syndrome by Proxy” Label*, 34 J. AM. ACAD. PSYCHIATRY & L. 90, 92 (Jan. 2006) (“[S]ome MSBP experts have admitted that they are not qualified to make a psychiatric diagnosis of the mother.”).

³⁶ By 1995, Roy Meadow himself lamented that the term's “over use has led to confusion for the medical, social work, and legal professions,” and that MSBP's diagnostic criteria “lack specificity: [too] many different occurrences fulfil them.” Meadow, *supra* note 32, at 534. In the United States, two psychologists—Loren Pankratz and Eric Mart—have provided the most persuasive critiques of the overbreadth of MSBP diagnostic criteria. See Mart, *supra* note 31; Pankratz, *supra* note 35; Loren Pankratz, *Persistent Problems with the “Separation Test” in Munchausen Syndrome by Proxy*, 38 J. PSYCHIATRY & L. 307 (2010).

which were later dismissed or the conviction overturned after strong evidence emerged that the children had actually died from genuine illnesses.³⁷

The discrediting of MSBP diagnoses in the United Kingdom did not diminish pediatricians' zeal to root out problematic parental behavior on this side of the Atlantic, however. Instead, the controversies surrounding MSBP prompted innovation. Beginning in the mid-1990s, two physicians—Carole Jenny, a pediatrician who specialized in child abuse, and her husband, Thomas Roesler, a psychiatrist—began to argue that MSBP was so flawed a concept that it needed to be scrapped.³⁸ The conduct at its core, they argued, should instead be dealt with by reconceptualizing it as a distinct form of child abuse, which they termed “medical

³⁷ See John Sweeney & Bill Law, *Gene Find Casts Doubt on Double ‘Cot Death’ Murders*, *GUARDIAN* (July 15, 2001, 6:54 PM EDT), <https://www.theguardian.com/uk/2001/jul/15/johnsweeney.theobserver>. Commenting later, the Royal Statistical Society declared that the “calculation . . . is invalid.”; see also Rebecca Hardy, *The Unending Nightmare: Ian and Angela Gay Speak Out*, *DAILY MAIL* (Mar. 5, 2007, 9:32 AM), <http://www.dailymail.co.uk/news/article-440053/The-unending-nightmare-Ian-Angela-Gayspeakout.html> (Ian & Angela Gay); Nicole Martin, *GMC Strikes off Meadow for ‘Abusing Position’ in Cot Death Trial*, *TELEGRAPH* (July 16, 2005, 12:01 AM BST), <http://www.telegraph.co.uk/news/uknews/1494147/GMC-strikes-off-Meadow-for-abusing-position-in-cot-death-trial.html>; *Mother Cleared of Killing Sons*, *BBC NEWS* (Dec. 10, 2003, 9:01 PM GMT), http://news.bbc.co.uk/go/pr/fr/-/2/hi/uk_news/england/wiltshire/3306271.stm; Stewart Payne, *Joy for Mother Cleared of Baby Deaths*, *TELEGRAPH* (June 12, 2003, 12:01 AM BST), <https://www.telegraph.co.uk/news/uknews/1432760/Joy-for-mother-cleared-of-baby-deaths.html>; David Pallister, *Solicitor Wrongly Jailed for Killing Sons Died from Excess Alcohol*, *GUARDIAN* (Nov. 8, 2007, 6:04 AM EST), <https://www.theguardian.com/society/2007/nov/08/childrens>; Thair Shaikh, *Sally Clark, Mother Wrongly Convicted of Killing Her Sons, Found Dead at Home*, *GUARDIAN* (Mar. 17, 2007, 5:22 AM EDT), <https://www.theguardian.com/society/2007/mar/17/childrensservices.uknews>. In 2004, the Attorney General of the United Kingdom opened an inquiry on previous MSBP convictions because of false diagnoses of MSBP and gross misstatements by expert witnesses. See Anthony Latest *Mother to Be Freed*, *BBC NEWS* (Apr. 11, 2005, 12:24 PM GMT), http://news.bbc.co.uk/go/pr/fr/-/2/hi/uk_news/england/somerset/4431851.stm. Although only a handful of appeals occurred, most were successful, including that of a mother who served six years for murdering her two infants. See *Baby Death Mother ‘Has Nothing,’* *BBC NEWS* (Apr. 12, 2005, 10:40 AM GMT), http://news.bbc.co.uk/2/hi/uk_news/england/somerset/4435989.stm.

³⁸ See ROESLER & JENNY, *supra* note 31, at 43-44, 46.

child abuse.”³⁹ Roesler and Jenny defined MCA broadly as any time “a child receives unnecessary and harmful or potentially harmful medical care at the instigation” of a parent.⁴⁰ From pediatricians’ perspective, this new conceptualization conveniently circumvented the objection that only an expert with mental health training could diagnose MSBP: it was well within pediatricians’ capability to “diagnose” abuse in the child.⁴¹ Indeed, some pediatricians were experts in just this.

The emerging subspecialty of child abuse pediatricians (CAPs), of which Carole Jenny is a prominent leader, was central to the rise of the MCA “diagnosis.”⁴² In the 1970s, as child abuse was increasingly recognized as a social problem, hospitals began to hire pediatricians to detect child abuse, rather than to treat their own patients,⁴³ although the field was not formally recog-

³⁹ See *id.* at 35, 56 (“If a large of group of pediatricians and child psychiatrists cannot come to agreement, why should we expect the community at large to understand what we are trying to identify, treat, and prevent? Let’s just call it child abuse.”).

⁴⁰ *Id.* at 43.

⁴¹ Jenny and Roesler themselves were somewhat ambiguous about whether their conception of MCA should be treated as a medical “diagnosis.” Compare, e.g., *id.* at 55 (“Is this really a syndrome?” “No . . . Child abuse is not an illness or a syndrome in the traditional sense but an event that happens in the life of the child.”), with *id.* at 142 (“In the 87 children we diagnosed with ‘medical child abuse’”). Subsequent pronouncements by the American Academy of Pediatrics make it clear that MCA should be treated as a medical diagnosis. See, e.g., John Stirling, Jr. & the Committee on Child Abuse and Neglect, *Beyond Munchausen Syndrome by Proxy: Identification and Treatment of Child Abuse in a Medical Setting*, 119 PEDIATRICS 1026, 1028 (2007) [hereinafter 2007 AAP Report] (“the falsification of a medical condition is a medical diagnosis”).

⁴² Among other positions, Jenny served as chair of the Section on Child Abuse and Neglect of the American Academy of Pediatrics, as well as the Chair of the Academy’s Committee on Child Abuse and Neglect. Jenny was also instrumental to the application to the American Board of Pediatrics for establishment of a subspecialty in Child Abuse and Forensic Pediatrics. Robert W. Block & Vincent J. Palusci, *Child Abuse Pediatrics: A New Pediatric Subspecialty*, 148 J. PEDIATRICS 711 (2006).

⁴³ The identification of child abuse as a subject for pediatric concern is often dated back to the publication of two papers by C. Henry Kempe and his colleagues. See C. Henry Kempe et al., *The Battered Child Syndrome*, 181 J. AM. MED. ASS’N 17 (1962); C. Henry Kempe et al., *Marginal Comment, Uncommon Manifestations of the Battered Child Syndrome*, 129 J. AM. DISEASES OF CHILDREN 1265 (1975); see also Steven C. Gabaeff, *Exploring the Contro-*

nized as a subspecialty of pediatrics until 2006.⁴⁴ As the field has developed, CAPS have been embroiled in controversies over the scientific accuracy of their diagnostic methods, recently prompting a wave of journalistic exposes on the issue.⁴⁵ Some, but not all, of this controversy surrounds CAPs' support for the diagnosis that had been known as "Shaken Baby Syndrome," but which CAPs have now renamed "Abusive Head Trauma," the underlying science of which has been increasingly questioned by scientists and courts.⁴⁶

versy in Child Abuse Pediatrics and False Accusations of Abuse, 18 *LEGAL MED.* 90 (2016) (describing the coalescing of this group of physicians).

⁴⁴ See Robert W. Block, *Child Abuse Subspecialty to Work with Primary Care Providers*, *AAP NEWS* (Nov. 2007), <https://www.aapublications.org/content/28/11/10>; Kristina Fiore, *Child Abuse Pediatricians Face Media Scrutiny*, *MEDPAGE TODAY* (Oct. 30, 2019), <https://www.medpagetoday.com/special-reports/exclusives/83024>.

⁴⁵ See, e.g., Keri Blakinger & Mike Hixenbaugh, '*Please Don't Take My Children*', *HOUSTON CHRON.* (Nov. 7, 2019), <https://www.houstonchronicle.com/news/houston-texas/houston/article/abuse-kids-CPS-children-doctors-14814201.php>; Fiore, *supra* note 44; Mike Hixenbaugh, *An ER Doctor Was Charged with Abusing His Baby. But 15 Medical Experts Say There's No Proof*, *NBC NEWS* (Jan. 27, 2020), <https://www.nbcnews.com/news/us-news/er-doctor-was-charged-abusing-his-baby-15-medical-experts-n1123756>; Mike Hixenbaugh, *Hundreds of Parents Say Kids Wrongly Taken From Them After Doctors Misdiagnosed Abuse*, *NBC NEWS* (Dec. 5, 2019), <https://www.nbcnews.com/us-news/hundreds-parents-say-kids-wrongly-taken-them-after-doctors-misdiagnosed-n1096091>; Mike Hixenbaugh & Keri Blakinger, *Burned by 'Bad Science'*, *HOUSTON CHRON.* (Oct. 24, 2019), <https://www.houstonchronicle.com/news/houston-texas/houston/article/Burned-doctor-medical-child-abuse-science-prison-14538710.php>; Mike Hixenbaugh & Keri Blakinger, *A Devastating Diagnosis*, *HOUSTON CHRON.* (Sept. 19, 2019), <https://www.houstonchronicle.com/news/investigations/article/A-Devastating-Diagnosis-14419072.php>; Mike Hixenbaugh & Keri Blakinger, '*Imminent Danger*', *HOUSTON CHRON.* (Oct. 10, 2019), <https://www.houstonchronicle.com/news/houston-texas/houston/article/Doctors-accuse-moms-of-abusing-their-children-14492174.php>; Eric Russell, *State's Rush to Judgment Almost Took This Boy from His Family*, *PRESS HERALD* (Jan. 26, 2020), <https://www.pressherald.com/2020/01/26/the-states-rush-to-judgment-almost-took-this-boy-away-from-his-family/>; Elizabeth Weill-Greenberg, *The State Convicted Him of Child Abuse. A Medical Expert Said It Was Likely Diaper Rash*, *THE APPEAL* (Jun. 29, 2021), <https://theappeal.org/child-abuse-diaper-rash-innocence-claim/>.

⁴⁶ The most notable among the scientific inquiries was undertaken in 2016 by the Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU), which appointed a panel of leading pediatricians and experts in forensic medicine, radiology, medical epidemiology, and medical and

research ethics to undertake a systematic review of the medical literature to assess the underlying strength of the SBS hypothesis and the validity of the diagnostic protocol used to identify SBS. After retrieving 3,773 medical papers and identifying 1065 of them as relevant, the SBU found that only thirty met the inclusion criteria of potentially providing evidence on the diagnostic methods used. Of these thirty papers, exactly zero of these papers were deemed high-quality research. Just two papers were deemed to be of moderate quality; the remaining 28 papers were deemed low quality. The most predominant flaw in this literature, the SBU found, was circular reasoning in the form of studies that treated doctors' unconfirmed identifications of SBS as genuine SBS cases for purposes of subsequent research—a research design that raised a high risk of introducing systematic bias into the results. The SBU ultimately concluded that the evidentiary foundation for SBS is of “very low quality,” and that “there is insufficient scientific evidence on which to assess the diagnostic accuracy of the triad in identifying traumatic shaking (very low quality evidence).” SWEDISH AGENCY FOR HEALTH TECHNOLOGY ASSESSMENT AND ASSESSMENT OF SOCIAL SERVICES, *Traumatic Shaking: The Role of the Triad in Medical Investigations of Suspected Traumatic Shaking—A Systematic Review* (2016), <https://www.sbu.se/255e> [<https://perma.cc/J5YW-S53C>]; see also Mans Rosen et al., *Shaken Baby Syndrome and the Risk of Losing Scientific Scrutiny*, 106 ACTA PÆDIATRICA 1905, 1906 (2017).

Other scientific evaluations of the SBS literature have reached similar conclusions. Lantz et al. discovered only two flawed case-control studies of the accuracy of the diagnosis, and concluded that much of the published work displayed an absence of precise and reproducible case definition, and interpretations or conclusions that overstep the data. Patrick E. Lantz et al., *Perimacular Retinal Folds from Childhood Head Trauma*, 328 BMJ 754, 754–56 (2004). Mark Donohoe found that “there was inadequate scientific evidence to come to a firm conclusion on most aspects of causation, diagnosis, treatment, or any other matters,” and identified “serious data gaps, flaws of logic, [and] inconsistency of case definition.” Donohoe also noted another research flaw that characterizes the SBS/AHT literature: particular assertions enter the relevant literature despite being premised on weak evidence, and are then cited and recited as established fact without being rigorously tested. In his words: “One may need reminding that repeated opinions based on poor-quality data cannot improve the quality of evidence.” That same research flaw pervades the literature on medical child abuse. Mark Donohoe, *Evidence-Based Medicine and Shaken Baby Syndrome Part I: Literature Review, 1966–1998*, 24 AM. J. FORENSIC MED. PATHOLOGY, 239, 241 (2003). Further, work by biomechanical engineers have cast doubt on the very possibility that simply violently shaking a child could produce enough force ever to produce one of the diagnostic signs, bleeding on the brain, at least without causing significant damage to the infant's neck, as well. See Faris A. Bandak, *Shaken Baby Syndrome: A Biomechanics Analysis of Injury Mechanisms*, 151 FORENSIC SCI. INT'L 71, 78 (2005) (“Head acceleration and velocity levels commonly reported for SBS generate forces that are far too great for the infant neck to withstand without injury. . . . [A]n

SBS diagnosis in an infant with intracerebral but without cervical spine or brain stem injury is questionable and other causes of the intracerebral injury must be considered.”); Jan E. Leestma, *Case Analysis of Brain-Injured Admittedly Shaken Infants: 54 Cases, 1969–2001*, 26 AM. J. FORENSIC MED. & PATHOLOGY 199, 211 (2005) (“[M]ost of the pathologies in allegedly shaken babies are due to impact injuries to the head and body”); Waney Squier, *Shaken Baby Syndrome: The Quest for Evidence*, 50 DEVELOPMENTAL MED. & CHILD NEUROLOGY 10, 13 (2008) (“[H]ead impacts onto carpeted floors and steps from heights in the 1 to 3 feet range result in far greater head impact forces and accelerations than shaking and slamming onto either a sofa or a bed”); Ronald H. Uscinski, *Shaken Baby Syndrome: An Odyssey*, 46 NEUROLOGIA MEDICO-CHIRURGICA 57, 59 (2006) (“[T]he hypothetical mechanism of manually shaking infants in such a way as to cause intracranial injury is based on a misinterpretation of an experiment done for a different purpose, and contrary to the laws of injury biomechanics as they apply specifically to the infant anatomy.”). *See also*, Debbie Cenziper, *Shaken Science: A Disputed Diagnosis Imprisons Parents*, WASH. POST (Mar. 20, 2015), <https://www.washingtonpost.com/graphics/investigations/shaken-baby-syndrome/> (biomechanical testing demonstrates that short falls results in far greater impact to the head than does shaking).

For court decisions that have questioned the science underlying the Shaken Baby Syndrome/Abusive Head Trauma diagnosis, see, e.g., *Del Prete v. Thompson*, 10 F. Supp. 3d 907, 909, 957 n.10 (N.D. Ill. 2014) (granting habeas corpus relief to a woman who had been convicted of murder for the death of a child in her care on the ground that the expert opinions presented at trial were “more an article of faith than a proposition of science.”); *People v. Bailey*, 999 N.Y.S.2d 713, 726 (N.Y. 2014) (overturning the murder conviction of a 55-year-old babysitter who had spent more than a decade in prison, on the ground “that a significant and legitimate debate in the medical community has developed in the past 13 years, over whether young children can be fatally injured by means of shaking”); *State v. Edmunds*, 746 N.W.2d 590, 592 (Wis. 2008) (overturning a conviction for first-degree reckless homicide after 11 years). It is notable that the trial expert whose testimony the *Del Prete* judge described as “more an article of faith than a proposition of science” was Emalee Flaherty, the chair of the committee on Abuse and Neglect that released the 2013 AAP Clinical Report accepting the medical child abuse diagnosis. *See* Emalee G. Flaherty, Harriet L. MacMillan & Committee on Child Abuse and Neglect, *Caregiver-Fabricated Illness in a Child: A Manifestation of Child Maltreatment*, 132 PEDIATRICS 590 (Aug. 2013), https://www.researchgate.net/publication/262044678_Caregiver-Fabricated_Illness [hereinafter 2013 AAP Report].

It is also notable that the government expert who asserted the scientific validity of the diagnosis at the *Del Prete* habeas hearing was Carole Jenny, co-originator of the MCA diagnosis. In the district judge’s words, Dr. Jenny’s testimony revealed (albeit with reluctance), “that the evidence basis for the proposition that shaking alone can cause injuries of the type at issue here is arguably non-scientific.” *Del Prete*, 10 F. Supp. 3d at 954.

In 2007, the American Academy of Pediatrics' Committee on Child Abuse and Neglect issued a report endorsing Roesler and Jenny's call for physicians to identify MSBP-type behavior as "medical child abuse" and adopting their broad MCA definition (2007 AAP Report).⁴⁷ Doing so greatly increased the types of cases in which CAPs would play a role beyond the bruises and broken bones they had mainly been charged with identifying in earlier decades. Indeed, the 2007 Report suggested that MCA should be investigated in all cases in which the caregiver insisted there was something wrong with the child but pathologic findings failed to explain the described signs or symptoms and contended that, "[w]henver possible, . . . a pediatrician with experience and expertise in child abuse [should] consult on the case, if not lead the team."⁴⁸ In 2013, the American Academy of Pediatrics again endorsed the concept of pediatricians "diagnosing" medical overtreatment as child abuse under the label of "MCA," or the closely-related terms of "caregiver-fabricated illness," "pediatric condition falsification," or "child abuse in the medical setting," and calling for physicians to "diagnose" the condition.⁴⁹ All such charges of alleged overtreatment by physicians will be referred to in this article as MCA charges, regardless of whether the physicians identified them as MCA or one of these alternative terms, as will claims styled as "MSBP," but in which a physician makes a "diagnosis" based on the child's medical records and treatment without a mental health examination of the parent. The closely allied psychological diagnosis of the parent, which is often called either MSBP or "factitious disorder imposed on another," will be referred to as MSBP.⁵⁰

⁴⁷ 2007 AAP Report, *supra* note 41, at 1029.

⁴⁸ *Id.* The 2017 APSAC Taskforce goes still further, declaring that "[o]nce all of the records are obtained directly from the treating facilities, . . . a professional with expertise in assessing suspected . . . MCA should organize and analyze them. It is *not* sufficient to have a clinician with general medical knowledge read the record." APSAC Taskforce, Munchausen by Proxy: Clinical and Case Management Guidance, AMERICAN PROFESSIONAL SOCIETY ON ABUSE OF CHILDREN (APSAC), 19 (2017) [hereinafter 2017 APSAC Taskforce] <https://2a566822-8004-431f-b136->.

⁴⁹ 2013 AAP Report, *supra* note 46, at 590.

⁵⁰ In 2013, the American Psychiatric Association for the first time included "factitious disorder imposed on another," a diagnosis related to MSBP, as an official diagnosis in its manual. *See id.* AMERICAN PSYCHIATRIC ASSOCIA-

B. MCA's Expanded and Ambiguous Definition

The conduct that the MSBP diagnosis had sought to target was generally limited to cases in which a parent lied about or induced symptoms in a healthy child.⁵¹ The definition of MCA that Roesler and Jenny adopted, and which continues to be used

TION, THE DIAGNOSIS AND STATISTICAL MANUAL OF MENTAL DISORDERS 325, § 300.19 (Am. Psychiatric Ass'n 5th ed. 2013) [hereinafter *DSM-V*]. This inclusion does not settle the issue of whether the MSBP diagnosis rests on an organized, scientific body of knowledge. Eric Mart and Loren Pankratz have already amply demonstrated that this diagnosis patently fails the test of scientific reliability. See generally MART, *supra* note 31; Pankratz, *supra* note 35; Pankratz *supra* note 36. Commentators have mustered persuasive critiques of the reliability of the American Psychiatric Association's process to select new diagnoses. See, e.g., Jack Drescher, *Out of DSM: Depathologizing Homosexuality*, 5 BEHAV. SCI. 565, 568-70 (2015) (arguing that past inclusion of homosexuality as a disorder was not based on legitimate scientific research, but on the subjective, unscientific opinions of early therapists, who had been influenced by psychoanalytic theories); Allen J. Frances, *DSM5 in Distress: Two Who Resigned From DSM-5 Explain Why*, PSYCHOL. TODAY BLOG (July 12, 2012), <https://www.psychologytoday.com/blog/dsm5-in-distress/201207/two-who-resigned-dsm-5-explain-why> (noting that two members of a DSM-5 working group on personality disorders resigned because of the group's "truly stunning disregard for evidence. Important aspects of the proposal lack any reasonable evidential support of reliability and validity. . . . Even more concerning is the fact that a major component of proposal is inconsistent with extensive evidence."); S. Nasir Ghaemi, *Why DSM-III, IV, and 5 Are Unscientific*, PSYCHIATRIC TIMES (Oct. 14, 2013) ("As so well documented by [Hannah S.] Decker and historian Edward Shorter and others who observed the process, . . . [the DSM] diagnoses were based almost entirely on the opinions and beliefs of leaders and interest groups in the psychiatric profession. . . . Were those ideas tested with observational studies, and then revised based on confirmations and refutations of their content? Not before 1980, and hardly since."). A Justice of the England and Wales High Court reached a similar conclusion in a concurring opinion. MSBP and related diagnoses "are child protection labels that are merely descriptions of a range of behaviours, not a paediatric, psychiatric or psychological disease that is identifiable. . . . In these circumstances, [such a diagnosis] in any individual case is as likely to be evidence of mere propensity which would be inadmissible at the fact finding stage . . ." *A County Council*, [2005] EWCH (Fam) 31, [178].

⁵¹ There were attempts to define MSBP more broadly as time wore on in order to include pervasive exaggerations of a child's symptoms, rather than the complete fabrication of an illness. See, e.g., C. J. Morley, *Practical Concerns About the Diagnosis of Munchausen Syndrome by Proxy*, 72 ARCHIVES DISEASE CHILDHOOD 528, 529 (1995) (criticizing extension of MSBP to a broader range of cases). Nevertheless, the basic pattern still generally held. See Rosen-

by CAPs, was far broader: MCA occurs any time “a child receives unnecessary and harmful or potentially harmful medical care at the instigation” of a parent.⁵² Yet this definition opens the door for CAPs to identify a vast spectrum of children’s medical care as abusive. Virtually all health care that children receive is “instigated” by a parent in the factual sense. Few children, obviously, have the wherewithal to make an appointment, get themselves to the doctor, explain to the doctor what their medical situation is, and pay for the appointment; even if they had, children lack the legal capacity to consent to most treatment. Although a diagnosis of MCA can be equated with child abuse only because the term “instigate” is read as a placeholder for some nefarious parental action, MCA can be diagnosed without any such showing.⁵³ Furthermore, physicians interpret the “potentially harmful” requirement of the MCA broadly to cover even a small risk of harm to the child, so that “[a]ny medical procedure, for example, a blood draw, or a trial of medication that is potentially harmful, could be considered abusive. . . .”⁵⁴ In addition, although MSBP was generally seen to require deliberate deception on the part of the parent motivated by her own secondary gain,⁵⁵ MCA is framed explicitly to exclude inquiry into parental motive or intent.⁵⁶

berg, *supra* note 34, at 424 (describing MSBP diagnosis by exclusion in terms of credibly excluding “all other possible explanations for the child’s condition”).

⁵² ROESLER & JENNY, *supra* note 31, at 43.

⁵³ The 2007 AAP Report, *supra* note 41, states simply that a doctor needs two circumstances to diagnose abuse: “harm or potential harm to the child involving medical care and a caregiver who is causing it to happen.” *Id.* at 1027-28.

⁵⁴ Reena Isaac & Thomas Roesler, *Medical Child Abuse*, in A PRACTICAL GUIDE TO THE EVALUATION OF CHILD PHYSICAL ABUSE AND NEGLECT 291, 291 (Eileen R. Giardino ed., 2d ed. 2010).

⁵⁵ Meadow suggested in his original paper that the mothers described seemed to “us[e] the children to get themselves into the sheltered environment of a children’s ward surrounded by friendly staff.” Meadow, *supra* note 27, at 345; *see also* Schreier, *supra* note 33 (“The primary motivation seems to be an intense need for attention from, and manipulation of, powerful professionals, most frequently, but not exclusively a physician.”).

⁵⁶ ROESLER & JENNY, *supra* note 31, at 43-44 (“[W]ith this definition it is not necessary to determine the parent’s motivation to know that a child is being harmed.”); *id.* (“[T]he definition and diagnosis of caregiver-fabricated illness in a child should focus on the child’s exposure to risk and harm and associated

Given this broad definition, once a child receives virtually any medical care, the only significant factor in restricting an MCA “diagnosis” will be whether the CAP concludes the care is unnecessary. Yet this determination will vary considerably among physicians. One national study of medical second opinions outside of the MCA context found that more than one in three physicians recommended treatment changes.⁵⁷ Rates of disagreement over treatment would likely be still higher for children with rare or complex medical conditions, who are most likely to be evaluated for MCA. It is unsurprising, then, that, when Dr. Jenny and Dr. Roesler applied their new definition of MCA to consider 115 cases they had earlier analyzed for MSBP, they discovered that MCA criteria identified more than three times as many cases than did MSBP diagnostic criteria—76% as compared to 25%.⁵⁸ What is surprising, however, is that this result did not cause alarm bells to ring for Roesler and Jenny, despite the fact that bringing such charges would subject three times as many families to the deep trauma inflicted by abuse charges. To the contrary, Roesler and Jenny touted the fact that their definition identified three times as many parents as abusers as an *advantage* of their approach.⁵⁹

Conceptualizing MCA this broadly allows CAPs to target an extensive array of parental conduct relating to children’s medical care, with no clear standards for making this determination. At the benign end of the spectrum, representative cases could include a parent’s simply seeking medication with which a CAP later disagreed (e.g., seeking a medication for a child’s nausea resulting from migraines); a mother’s seeking care for her child because she was overly anxious or traumatized by an earlier pediatric emergency; and a mother’s innocent misstatement of a

injuries or impairment rather than the motivation of the offender. Caregiver-fabricated illness in a child is best defined as maltreatment that occurs when a child has received unnecessary and harmful or potentially harmful medical care because of the caregiver’s fabricated claims or signs and symptoms induced by the caregiver.”).

⁵⁷ Ashley Meyer, Hardeep Singh & Mark Graber, *Evaluation of Outcomes from a National Patient-Initiated Second-Opinion Program*, 128 AM. J. MED. 1138 (2015).

⁵⁸ ROESLER & JENNY, *supra* note 31, at 142-47 (using Donna A. Rosenberg’s diagnostic criteria for MSBP).

⁵⁹ *See id.*

child's condition. Toward the middle of the spectrum, it could include the relatively common occurrence of a parent who exaggerates a child's symptoms to get treatment the parent believes necessary ("my child hasn't slept in days");⁶⁰ a parent who unintentionally overstates a child's condition because she was misled by the child; and a parent who suffers from "hypochondriasis by proxy," and therefore reports false symptoms she genuinely believes are true.⁶¹ Finally, at the more blameworthy end of the spectrum, it could include MSBP-type behavior—the intentional lie or inducement of symptoms to get the child medical care that the parent knows is unnecessary. Under the label of "MCA," all these behaviors become identifiable as "overmedicalization," and pathologized as abuse at the CAP's discretion.

Despite MCA's far broader standards than MSBP, CAPs still frequently suggest that the parents identified by the MCA definition are psychopaths intent on hurting their children, who "use [physicians'] trust to exaggerate, fabricate, or induce symptoms resulting in diagnoses, medications, procedures, and attention."⁶² This is despite the fact that a large portion of the behavior that falls within the broad definition of MCA would otherwise be considered simple differences of opinion between mothers and doctors, differences of opinions between two sets of doctors, an innocent mistake on the parent's part, or a slight, within-the-bell-curve-of-normal exaggeration by a concerned parent.⁶³ It would be far clearer for the evaluating pediatrician to specify the particular parental behavior deemed wrongful, for ex-

⁶⁰ Morley, *supra* note 51, at 528 ("Many mothers are just over anxious and trying to get the doctor to listen, or exaggeration may be part of her normal language.").

⁶¹ The term is Eric Mart's. See MART, *supra* note 31, at 26.

⁶² Allison M. Jackson et al., *Aspects of Abuse: Recognizing and Responding to Child Maltreatment*, 45 CURRENT PROBS. PEDIATRIC & ADOLESCENT HEALTH CARE 58, 64 (2015).

⁶³ See Meadow, *supra* note 27, at 344-45 ("We recognise that parents sometimes exaggerate their child's symptoms, perhaps to obtain faster or more thorough medical care of their child."); Morley, *supra* note 51, at 529 ("[M]others frequently exaggerate their child's symptoms, not through any malignant desire to mislead the doctor but as part of common language: 'he hasn't eaten a thing all week', 'he vomits up all the feed'. Such phrases are part of everyday life and experienced paediatricians do not take the mother's story at face value but take a careful history to find out exactly what has been happening.").

ample stating “I think you were being overly anxious and didn’t need to bring the child to the doctor.” Or “I think you mistakenly gave the other doctor an incorrect picture of the child’s symptoms. I don’t think the child’s nausea merited a prescription for Zofran.” Yet framing the parents’ behavior as “abuse” impugns the parents’ motives before a court (without requiring the physician to have evidence that such a motive existed) and gives the physician a potential legal lever to interfere coercively with the parent’s decision-making. In contrast, framing the conflict as a simple disagreement between a doctor and a parent over what medical care the child needs allows a doctor no power to dictate the child’s medical care, given that parents have a constitutional right to make health care decisions for their children absent abuse.⁶⁴

The vast expansion in doctors’ supervisory power over parents’ medical decisions provided by the MCA definition was not motivated by empirical literature that established actual problems with parents’ decision-making beyond the MSBP context.⁶⁵ Indeed, the far more significant threat to children’s health documented in empirical literature is not parents’ attempts to overmedicate their children, but doctors’ own mistakes in providing care,⁶⁶ particularly through misdiagnosing children.⁶⁷ Dr.

⁶⁴ See *infra* Part II.

⁶⁵ Chapter 2 of Roesler & Jenny’s book, which makes the case for the movement from the MSBP model to the MCA model, points only to the controversies regarding MSBP as reasons to shift to the MCA model. See ROESLER & JENNY, *supra* note 31, at 43-60.

⁶⁶ In 1999, an Institute of Medicine report described medical errors as an “epidemic.” INST. OF MED., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH CARE SYSTEM* (1999), <https://www.nap.edu/resource/9728/To-Err-is-Human-1999—report-brief.pdf>. A subsequent study in the *BMJ* found that “medical errors in hospitals and other health-care facilities are common and may be the third-leading cause of death in the United States—claiming 251,000 lives every year, more than respiratory disease, accidents, stroke and Alzheimer’s.” Ariana Eunjung Cha, *Researchers: Medical Errors Now Third Leading Cause of Death in United States*, WASH. POST (May 3, 2016), <https://www.washingtonpost.com/news/to-your-health/wp/2016/05/03/researchers-medical-errors-now-third-leading-cause-of-death-in-united-states> (citing Martin Makary & Michael Daniel, *Medical Error—The Third Leading Cause of Death in the U.S.*, 353 *BMJ* (2016)). For documentation of the widespread problem of misdiagnosis, see INST. OF MED., *IMPROVING DIAGNOSIS IN HEALTH CARE* 19, 37 (Erin P. Balogh, Bryan T. Miller, & John R. Ball eds. 2015), <http://>

Jenny and Dr. Roesler did not address these more pervasive threats to children associated with the health care system. Indeed, their concept of MCA increases the threat of medical mistakes to children by attributing blame for unnecessary medical care to parents rather than doctors, making it more likely that the mistakes will not be corrected.⁶⁸

C. Medical Child Abuse Charges Today

Since Doctors Roesler and Jenny first proposed it, U.S. physicians' preferred way to conceptualize and deal with the perceived problem of medical overtreatment by parents has been to identify it as child abuse under the label of "MCA"⁶⁹ Doctors are now being trained to treat MCA as a diagnosis that should be routinely considered in complicated medical cases,⁷⁰ and to re-

www.nationalacademies.org/hmd/Reports/2015/Improving-Diagnosis-in-Healthcare.aspx; Eta S. Berner & Mark L. Graber, *Overconfidence as a Cause of Diagnostic Error in Medicine*, 121 AM. J. MED. S2, S3, S4 tbl. 1 (2008); Helene Epstein, *Why It's So Easy for Doctors to Misdiagnose Kids*, ATLANTIC (Nov. 17, 2015), <http://www.theatlantic.com/health/archive/2015/11/why-its-so-easyfordoctors-to-misdiagnose-kids/416112/>(citing Hardeep Singh et al., *The Frequency of Diagnostic Errors in Outpatient Care: Estimations from Three Large Observational Studies Involving US Adult Populations*, 23 BMJ QUALITY & SAFETY 727, 731 (2014)).

⁶⁷ See SHIRE, RARE DISEASE IMPACT REPORT (Apr. 2013), <https://globalgenes.org/wp-content/uploads/2013/04/ShireReport-1.pdf>.

⁶⁸ Indeed, in the Houston case of Katie Ripstra, Stanford University kidney specialist Dr. Steven Alexander testified that the first time he looked at Ripstra's daughter's file, he thought he was being asked to review a potential medical malpractice case based on the medical treatment that the child had received. See Meagan Flynn, *Defense Claims Girl's Illness Stumped Doctors, So They Blamed Salt Poisoning*, HOUS. PRESS (Sept. 23, 2015, 11:30 AM), <https://www.houstonpress.com/news/defense-claims-girls-illness-stumped-doctors-so-they-blamed-salt-poisoning-7787782>. Instead, based on expert testimony diagnosing MCA, Ripstra was sentenced to two twenty-year sentences in prison. Flynn, *supra* note 7.

⁶⁹ See APSAC Taskforce, *Munchausen by Proxy: Clinical and Case Management Guidance*, AMERICAN PROFESSIONAL SOCIETY ON ABUSE OF CHILDREN (APSAC) 19 (2017) [hereinafter 2017 APSAC Taskforce], https://2a566822-8004-431f-b136-8b004d74bfc2.filesusr.com/ugd/4700a8_47be1e8b569a428dad3e41fd366e2f4f.pdf.

⁷⁰ For example, the 2007 AAP Report suggested that MCA should be investigated in all cases in which the caregiver insisted there was something wrong with the child but pathologic findings failed to explain the described signs or symptoms. 2007 AAP Report, *supra* note 42, at 1029.

port suspicions of MCA to child protection authorities.⁷¹ Mental health professionals, nurses, clergy, and social workers are likewise being taught to be vigilant to possible MCA cases in order to protect children from harm.⁷² The fact that physicians are urged to consider MCA whenever they see “children with highly unusual clinical presentations, when clinical findings are unexpectedly inconsistent with the reports of the caregiver, or when a child’s response to standard treatments is surprising” means that many parents of children with rare or undiagnosed genetic diseases will face scrutiny for abuse.⁷³ Unfortunately, nothing in the “diagnostic” process used by CAPs reliably rules such parents out.⁷⁴

The importance of identifying possible cases of MCA is hyped by statistics relating to prevalence and severity that are poorly supported by science but are nevertheless repeatedly restated in the medical literature. Two weaknesses in the science are especially prominent in this literature. First, particular assertions enter the relevant literature despite being premised on weak evidence, and are then cited and recited as established fact without being rigorously tested. Second, doctors’ identifications of MSBP or MCA in past cases are treated as confirmed diagnoses for the purposes of research that seeks to discern how to identify future MCA cases — a tautologous mode of research

⁷¹ See *id.* (“If the parent’s care-seeking is harming the child but the parent refuses to cooperate with the physician in limiting the amount of medical care to an appropriate level, the state child protective services agency should be informed.”); STATE OF MICHIGAN GOVERNOR’S TASK FORCE ON CHILD ABUSE AND NEGLECT, MEDICAL CHILD ABUSE: A COLLABORATIVE APPROACH TO IDENTIFICATION, INVESTIGATION, ASSESSMENT AND INTERVENTION 1, 3 (Mich. Dep’t of Hum. Servs., 2013), https://www.michigan.gov/documents/dhs/DHS_PUB_0017_200457_7.pdf [hereinafter 2013 MICH. TASK FORCE REP.] (“When a medical provider, or other person, recognizes that the child may be a victim of Medical Child Abuse and is at risk of harm, a report should be made with CPS”).

⁷² *E.g.*, Flyer from Megan Goodpasture, M.D., for training on Medical Child Abuse: A Review of Caregiver Fabricated Illness and Its Impact on Children, Families and the Medical Team at the Wake Forest Baptist Medical Center (June 14, 2016) (on file with author) (suggesting MCA training be attended by “nurses, doctors, social workers, clergy, and any interested health care professional”).

⁷³ 2017 APSAC Taskforce, *supra* note 69, at 8.

⁷⁴ See *infra* Part III.

that cannot separate out spurious from genuine characteristics. These are the same flaws that have led scientists, and more recently a number of courts, to reject the proof of another diagnosis that CAPs have vociferously pressed – that of Shaken Baby Syndrome, which CAPs have now renamed “Abusive Head Trauma,” in part in response to these critiques.⁷⁵

Take, for example, the discussion of MCA rates set out in the 2017 American Professional Society on the Abuse of Children (APSAC) Practice Guidelines on Munchausen by Proxy, a document that courts have treated as an authoritative, scientific pronouncement on MCA.⁷⁶ The Guidelines state that the rate of MCA cases is “approximately from .5 to 2.0 per 100,000 children younger than 16 years,” and cites the 2013 AAP Report for the figure.⁷⁷ However, the 2013 AAP Report cited does not calculate MCA incidence rates itself. Instead, it repeats rates cited in significantly older (1987, 1996, and 2001) studies seeking to measure rates of MSBP behavior, rather than the far broader category of MCA behavior.⁷⁸ Further, the methodology of these older studies is both unscientific and dubious, even as it pertains to incidence rates of MSBP behavior in other countries. For example, the high estimate of 2.0 per 100,000 children is derived from a 2001 New Zealand study on MSBP.⁷⁹ In that study, the authors simply surveyed pediatricians regarding how many cases of MSBP they had seen in the last year that they either reported to child protection officials or they believed were highly suspicious, without making any attempt to confirm whether the pediatri-

⁷⁵ See *supra* note 46, and accompanying text.

⁷⁶ See, e.g., *In re A.B.*, No. B297961, 2019 WL 6522031, at *9, 11 (Cal. Ct. App. Dec. 4, 2019) (relying on APSAC Practice Guidelines recommendations, described as “reflect[ing] current knowledge about best practices related to identification, reporting, assessment, and management” of MCA to deny grandfather of mother accused of MCA from custody of or visitation with child).

⁷⁷ 2017 APSAC Taskforce, *supra* note 69, at 5.

⁷⁸ See 2013 AAP Report, *supra* note 46, at 592, 595 (citing Rosenberg, *Web of Deceit*, *supra* note 33, R.J. McClure et al., *Epidemiology of Munchausen Syndrome by Proxy, Non-Accidental Poisoning, and Non-Accidental Suffocation*, 75 ARCHIVES DISEASE CHILDHOOD 57 (1996); S.J. Denny et al., *Epidemiology of Munchausen Syndrome by Proxy in New Zealand*, 37 J. PAEDIATRICS & CHILD HEALTH 240, 240 (2001)).

⁷⁹ See Denny et al., *supra* note 78, at 240.

cian's suspicions were correct in any of the cases.⁸⁰ To the extent that reporting physicians wrongly suspected MPSP, which, given what we know about the number of wrongful diagnoses of MSBP during this period is eminently possible,⁸¹ this study fails to convey reliable information about actual MSBP incidence rates in New Zealand twenty years ago, let alone about in the United States today.

Not content simply to repeat these poorly supported MCA rates as fact, the APSAC Practice Guidelines then attempt to heighten the urgency associate with MCA by stating that "this form of abuse and neglect is significantly underrecognized and underreported. Therefore, these estimates likely underrepresent the actual extent of this abuse."⁸² The Guidelines provide no citation to support this assertion; however, the 2013 AAP Report makes this same claim, citing a 1996 study by McClure et al. that analyzed surveys of pediatricians in the UK and Ireland during 1992-94.⁸³ The AAP Report's assertion about the 1996 study, however, derives solely from the fact that, when pediatricians who had reported MSBP behavior were asked about their confidence that their suspicions of MSBP were correct,

one hundred and nine (85%) of pediatricians estimated the probability of their (MSBP) diagnosis being correct as greater than 90%. In 14 cases [the pediatrician estimated] the probability of abuse was estimated to be between 71% and 90% and in four, between 50% and 70%. In only one case was the probability less than 50%.⁸⁴

From this, the AAP Report derives the tenuous conclusion that, "it appears that pediatricians needed to have a strong degree of certainty before reporting, suggesting that many cases go unreported when a physician is less sure of the diagnosis."⁸⁵ Yet even leaving aside the possibility that U.S. pediatricians thirty years later might not be reporting at the same rates and level of confidence as UK and Ireland pediatricians decades before, and that reporting rates may be very different for MCA than MSBP given

⁸⁰ *See id.* at 241.

⁸¹ *See supra* note 37 and accompanying text.

⁸² 2017 APSAC Taskforce, *supra* note 69, at 5.

⁸³ 2013 AAP Report, *supra* note 46, at 592 (citing McClure et al. *supra* note 78).

⁸⁴ McClure, *supra* note 78, at 59.

⁸⁵ 2013 AAP Report, *supra* note 46, at 592.

the different diagnostic criteria, this conclusion holds only if both the pediatricians who responded were in fact correct about their MSBP diagnoses that they did report, and, in addition, they did not report correctly diagnosed cases of MSBP when they were less confident of their diagnosis. The McClure study provides no data that answer these questions. However, we now know that pediatricians of that era in the United Kingdom, including Roy Meadow, a coauthor of the study, were overconfident of their diagnoses of MSBP, and made false diagnoses based on overly broad diagnostic criteria.⁸⁶ This suggests that, what the McClure study reveals—contrary to the suggestion of the 2013 AAP Report—is not underreporting by pediatricians of true MSBP behavior, but instead overconfidence in false diagnoses of MSBP. Nevertheless, the 2017 APSAC Practice Guidelines presents this tenuously derived assertion as scientific fact.

Similarly, the 2017 APSAC Practice Guidelines make several supposedly scientific assertions that suggest that returning a child who is medically abused to the parent will put the child in severe danger. For example, the Guidelines state:

Re-abuse (further falsification or other abuse or neglect) is a risk for children who have been deemed by CPS [child protective services] or the courts to be safe to return to the home of the abuser. Re-abuse rates have been found to range from 17% for mild cases of MBP to 50% for moderate cases.⁸⁷

The Guidelines cite two studies to support these alarming statistics. The first is a 1993 co-authored article by Bools, Neale, and Meadow that followed up on 54 children who had previously been determined to be victims of MSBP to see if their symptoms and physical condition had improved once the MSBP was diagnosed, and which found that many children still exhibited symptoms. That study, though, should be deemed completely discredited. Not only were the original MSBP diagnoses in that study not independently confirmed, Roy Meadow, one of the study's co-authors, stated that the bulk of these cases were accessible to the researchers because he had been consulted as an expert on MSBP on many of them.⁸⁸ As an expert, Meadow

⁸⁶ See *supra* note 37.

⁸⁷ 2017 APSAC Taskforce, *supra* note 69, at 22.

⁸⁸ See C. N. Bools, B. A. Neale, & S.R. Meadow, *Follow-up of Victims of Fabricated illness (Munchausen Syndrome by Proxy)*, 69 ARCHIVES DISEASE

presumably had an instrumental role in making the determinations of MSBP presumably in these cases. Yet, as the AAP certainly knew, Meadow's diagnostic methods were grossly unscientific and rendered significant numbers of false-positive results.⁸⁹ The result was not only that at least five murder convictions of mothers based on his testimony were later overturned, but also that the UK Medical Council publicly condemned him for violating his expert authority, which "carried with it a unique responsibility to take meticulous care in a case of this grave nature." It continued: "You should not have strayed into areas that were not within your remit of expertise. Your misguided belief in the truth of your arguments is both disturbing and serious."⁹⁰ If, as seems likely, Meadow mistook genuine genetic illnesses for MSBP in cases cited in the article as well, it would be unsurprising that so many of the children still had symptoms at the time he followed up. The problem, though, was not the "re-abuse" the AAP asserts, but rather false positive determinations of abuse – a possibility that the AAP does not mention.

The second article cited to support the AAP's alarming statistics on "re-abuse" was a 1998 article, also co-authored by Roy Meadow, which was also grossly flawed in method. This 1998 article treated any case for which a formal child protection case conference was held, regardless of the conference's findings, as if it were a confirmed case of MSBP, excluding it only if the reporting physician did not have a great degree of certainty about the

CHILDHOOD 625, at n.7 and accompanying text (1993) (noting that study relied on data from Bools, Neale, and Meadow, 1992); C. N. Bools, B. A. Neale, & S. R. Meadow, *Co-morbidity Associated with Fabricated Illness (Munchausen Syndrome by Proxy)*, 67 ARCHIVES DISEASE CHILDHOOD 77, 77 (1992), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1793550/pdf/archdisch00642-0007.pdf>.

⁸⁹ See *supra* note 37.

⁹⁰ Martin, *supra* note 37 (quoting General Medical Council's opinion). Although the General Medical Council removed Meadow's ability to practice because of his "erroneous" and "misleading" testimony, see David Batty, *Q&A: Sir Roy Meadow*, GUARDIAN (Feb. 17, 2006, 10:33 AM GMT), <https://www.theguardian.com/society/2006/feb/17/NHS.health>, that decision was subsequently overturned by the Court of Appeals. See Joshua Rozenberg, *Sir Roy Meadow, the Flawed Witness, Wins GMC Appeal*, TELEGRAPH (Feb. 18, 2006, 12:01 AM GMT), <http://www.telegraph.co.uk/news/uknews/1510798/Sir-Roy-Meadow-the-flawed-witness-wins-GMC-appeal.html>.

MSBP determination.⁹¹ The authors then surveyed the reporting pediatrician for his or her opinion about whether the child had been “re-abused” in the aftermath of the case conference. Given that no attempt was made to confirm the accuracy of the original MSBP charges, aside from measuring the confidence of the reporting physician, all that can truly be ascertained from the study is that the pediatricians who reported MSBP had a high confidence that they themselves were correct about these diagnoses and that, among the 30 children that had case conferences for MSBP who were not physically harmed, and who were subsequently returned to their homes, the reporting physicians believed that two were subsequently “reabused” through MSBP and that another three were emotionally abused—making the total rate of children that physicians believed were subsequently abused in any manner 5 of 30, or 17%.⁹² This is hardly the stuff of which high-quality science is composed.

Once physicians report suspected abuse to child protection authorities, because these authorities generally do not have a doctor on staff, they often turn to outside experts. Very often, this is the child abuse protection team of the same hospital from which the report was just made.⁹³ The protocol CAPs then use to make the determination inserts them into complicated medical cases in which they sometimes assert the presence of MCA over the objections of the child’s treating doctors—often experienced specialists who believe that the child has one or more genuine medical diagnoses.⁹⁴ Nevertheless, child protection authorities in

⁹¹ P. Davis, R. McClure, K. Rolfe, N. Chessman, S. Pearson, J. Sibert & R. Meadow, *Procedures, Placement, and Risks of Further Abuse After Munchausen Syndrome by Proxy, Non-accidental Poisoning, and Non-accidental Suffocation*, 78 ARCHIVES DISEASE CHILDHOOD 217 (1998).

⁹² *Id.* at 219.

⁹³ See, e.g., Swidey & Wen, *supra* note 5 (noting that Massachusetts Department of Children and Families has longstanding ties with Boston Children’s Hospital (BCH), and treats the hospital as MCA experts even in cases in which the report of abuse comes from BCH).

⁹⁴ See, e.g., *In re McCabe*, 580 S.E.2d 69, 72-74 (N.C. Ct. App. 2003) (accepting child abuse pediatricians’ diagnosing a child with MSBP over a cardiologist’s contrary diagnosis). In one such case, CAP Dr. Adelaide Eichman, within months after she completed her residency, determined that a child needed to be “de-medicalized” based on reading the child’s medical records, despite the view of the child’s specialists that the child had several genuine medical diagnoses and might still have undiagnosed conditions. See Transcript

at least many of these cases treat the evaluating pediatrician's "diagnosis" of MCA — often made without examining the child or meeting the child's parents—as authoritative.⁹⁵ This gives the pediatricians in this new subspecialty, in the words of Dr. Eli Newberger, a pediatrician who founded the child protection team at Boston Children's Hospital in 1970, but now acts as an expert witness on behalf of parents, "enormous and really unchecked power."⁹⁶

At trial on these charges, judges generally give CAP opinions great credence, on the ground that they are experienced at both detecting abuse and making medical diagnoses.⁹⁷ In doing

of Child Abuse Appeal of D.H. Hearing at 26-27, 48-49, *In re G.M.*, No. 329-2014 (Penn. Dep't Hum. Servs.) (Sept. 29, 2015) [hereinafter Child Abuse Appeal of D.H.]. After the medical records that Dr. Eichman relied on to diagnose abuse were determined to be inaccurate, the child was eventually returned to her mother's custody and the finding of abuse was expunged—still over the objection of Dr. Eichman. *See id.* at 106. In another case, Jessica Hilliard was charged with MCA for seeking medical care for her son despite the fact that an expert in mitochondrial disease had diagnosed the child as having mitochondrial dysfunction and the child's other sister had already died from what two outside specialists concluded was a genetic disease that affected mitochondrial function. *See Eichner, supra* note 18. Other cases in which child abuse pediatricians disputed the diagnoses of specialists in the field of the child's symptoms include the *Ripstra* case described in Flynn, *supra* note 7; the *Parker* case described in Wagner, *supra* note 7; and the *Pelletier* case, described *supra* notes 11-18 and accompanying text.

⁹⁵ *See, e.g.,* Child Abuse Appeal of D.H., *supra* note 94, at 106. (when asked why the county found a physician's report of MCA to be substantiated, despite considerable evidence to the contrary, the county case worker responded: "We have to go based upon the statement from the [charging child abuse] medical professional. We cannot get from each individual doctor what they feel in regards to it. We solely rely on the statement from the three [child abuse pediatricians] at the Child Advocacy Clinic."); Swidey & Wen, Wen, *supra* note 5 ("In Massachusetts, the Department of Children and Families . . . is supposed to be a neutral referee assessing the charges against the parents. Many parents and their advocates complain, however, that the state agency, because of its lack of in-house medical expertise and its longstanding ties with [BCH], is overly deferential to the renowned Harvard teaching hospital.")

⁹⁶ Swidey & Wen, *supra* note 5 ("Newberger said he's seen a tendency for state child-welfare agencies to be 'overly credulous to hospitals' and for some child protection teams to show a 'reflexive willingness to label and to punish,' especially educated mothers who are perceived as being too pushy.")

⁹⁷ *See, e.g., In re Adoption of Keefe*, 733 N.E.2d 1075, 1079 (Mass. App. Ct. 2000); *see In re J.M.*, No. 1339 EDA 2018, 2018 WL 5857891, at *6 (Pa.

so, they fail to recognize that MCA is not a genuine medical diagnosis,⁹⁸ and that the supposed “diagnostic” process CAPs use to identify cases of MCA is not only vastly different from the standard differential diagnosis process, but also untested and unreliable.⁹⁹ Courts also accept CAP claims that MCA is essentially the same diagnosis as MSBP, despite the fact that MCA requires no proof of psychopathology on the part of the parent, uses criteria that are far easier than MSBP to meet, and few cases present any strong evidence of the psychopathology required for MSBP.¹⁰⁰ From the judge’s perspective, on hearing that the state’s medical expert believes the parent is a serious risk to the child’s safety, (a belief based on flawed science,) the far smaller risk is to remove custody from the parent.¹⁰¹ Ultimately, some parents have their parental rights terminated completely as a result of these charges.¹⁰² Other parents retain custody either by agreeing to outside supervision of their medical decisions for the child or by having such supervision imposed on them.¹⁰³ Still others eventu-

Super. Ct. Nov. 9, 2018) (basing aggravated abuse determination on the “credible and insightful” testimony of CAP that the “[c]hild was the victim of medical child abuse and neglect through Mother’s factitious disorder imposed on another, formerly Munchausen syndrome by proxy.”); *Id.* at *6 (“The trial court found this testimony credible and insightful. [The CAP] testified with a reasonable degree of medical certainty that Child was the victim of medical child abuse and neglect through Mother’s factitious disorder imposed on another, formerly Munchausen syndrome by proxy.”).

⁹⁸ See *infra* at Part IV.B.ii.

⁹⁹ See *infra* at Part III.

¹⁰⁰ See, e.g., *McCabe*, 580 S.E.2d at 71 (accepting the diagnosis of MSBP by child abuse pediatricians despite absence of mental health professional proof or any strong evidence to suggest such issues); *In re Z.S.*, No. 25986, 2014 WL 4267478 at ¶¶ 2-3 (Ohio Ct. App. Aug. 29, 2014) (pediatrician diagnoses MCA, presented as the same diagnosis as MSBP).

¹⁰¹ See, e.g., *Z.S.*, 2014 WL 4267478 at ¶16; *J.M.*, 2018 WL 5857891.

¹⁰² See, e.g., *Shawna N. v. Dep’t of Child Safety*, No. 1 CA-JV 18-0255, 2020 WL 207071, at *1 (Ariz. Ct. App. Jan. 14, 2020); see, e.g., *In re A.J.B.*, No. 12-0071, 2012 WL 1066483 (Iowa Ct. App. Mar. 28, 2012).

¹⁰³ This was the case in a lawsuit filed by two Massachusetts parents against the Massachusetts Department of Children and Families for violations of their parental rights. See Memorandum of Law *ex rel.* 7 (July 17, 2014), *Karen T. & Robert T. Sr. v. Deveney*, Civ. Action 1:14-cv-12307 (D. Mass. 2014) (state requires parents to identify a new pediatrician to oversee the child’s care, and later intervenes to recommend that the parents take the child to psychological counseling).

ally have such charges dismissed, but only after months of separation from their children, thousands of dollars in legal fees, and, they report, harm resulting from changes to the child's medical care in the interim.¹⁰⁴

Parents suspected of MCA find themselves placed in a Kafkaesque situation. The fact that their child has a probable or confirmed alternative diagnosis from another doctor does not negate a diagnosis of MCA.¹⁰⁵ Neither does the fact that some other doctor ordered the medical care deemed abusive, documented the medical reasons for it, or even still believes that the medical treatment that the child received was appropriate.¹⁰⁶ Instead, such doctors are deemed the unwitting dupes of the parent's deception.¹⁰⁷ Martin Guggenheim, a law professor at New York University, likens the situation of parents charged with MCA to that of women accused of witchcraft by "experts" in the seventeenth century: "If the expert declares that you're a witch, how in the world can you begin to prove that you're not?"¹⁰⁸ The comparison to witchcraft may be particularly apt given the MCA literature's description of the considerable powers that MCA mothers have to bend doctors and others to their will in order to

¹⁰⁴ This was the case for Justina Pelletier's family. *See supra* note 14 and accompanying text. *See also* Eric Russell, *State's Rush to Judgment Almost Took This Boy from His Family*, PRESS HERALD (updated May 27, 2020), <https://www.pressherald.com/2020/01/26/the-states-rush-to-judgment-almost-took-this-boy-away-from-his-family/>.

¹⁰⁵ For examples of cases in which MCA charges were brought despite a child having a suspected or confirmed diagnoses from another doctor, *see, e.g.*, Eichner, *supra* note 18 (*Hilliard* case); Neil Swidey, *The PANDAS Puzzle: Can a Common Infection Cause OCD in Kids?*, BOS. GLOBE (Oct. 28, 2012), <https://www.bostonglobe.com/magazine/2012/10/27/the-pandas-puzzle-can-common-infection-cause-ocd-kids/z87df6Vympu7bvPtapETLJ/story.html>; Swidey & Wen, *supra* note 14 (*Pelletier* case) (quoting attorney for parents, Beth Maloney, who argued at MCA hearing: "What we have is an argument within the medical community about whether infection can cause behavioral disorders and mental health issues . . . And Boston Children's Hospital is going to work that out on the backs of parents in your courtroom.").

¹⁰⁶ *See* sources cited *supra* note 105.

¹⁰⁷ *See, e.g.*, 2013 MICH. TASK FORCE REP., *supra* note 71, at 5 ("In many cases, parents who engage in this form of abuse are effective at rallying allies or locating one or more providers who are vulnerable to their deceptions rather than accepting the possibility of Medical Child Abuse.").

¹⁰⁸ Telephone interview with Martin Guggenheim, Fiorello LaGuardia Professor of Law, NYU School of Law (July 24, 2014).

hurt their children,¹⁰⁹ as well as the fact that it is almost universally women who are accused of masterminding MCA.¹¹⁰

II. The Medical Child Abuse Theory and Parents' Constitutional Rights

Parents' right to make health-care decisions for their children is one of the fundamental liberty interests protected by the U.S. Constitution. Although this decision-making right is limited by prohibitions on child abuse and neglect, as this Part shows, the broad definition of MCA now being propounded by CAPs was created without giving deference to parents' rights to determine their children's health care. CAPs' definition of MCA expands the meaning of the term "child abuse" far beyond its current legal meaning. In doing so, it unconstitutionally eviscerates parents' decision-making authority in a broad range of cases.

¹⁰⁹ See, e.g., *In re A.B.*, No. B297961, 2019 WL 6522031, at *8-9 (Cal. Ct. App. Dec. 4, 2019) ("most of the perpetrators are articulate, convincing, and sympathetic Even the most well intended, skilled, and committed relatives may have great difficulty enduring unrelenting pressure from the abusive caregiver to gain access to and control over the victim.").

¹¹⁰ Viewing mothers as the instigator of abuse derives from MSBP diagnostic practices, which generally profiled the perpetrator as the mother. See McClure et al., *supra* note 78, at 59 (identifying the mother as the sole perpetrator in 85% of cases), *cited in* 2013 AAP Report, *supra* note 46, at 592. The link between MCA charges and the long history of gender stereotypes that have been invoked to impugn women's judgment and restrict their autonomy merits significant further consideration. In the United States, this history extends back not only to the trials of witches, but also to the medical diagnosis of "hysteria," which was increasingly applied to women by medical doctors in the nineteenth century. See ELAINE SHOWALTER, *THE FEMALE MALADY: WOMEN, MADNESS, AND ENGLISH CULTURE, 1830-1980*, at 145-64 (1985). Medical child abuse charges also bear similarity to forced interventions involving pregnant women insofar as both construe the actions of mothers as inimical to the interests of their children, often with scant evidence to support such a conflict. See Lynn M. Paltrow & Jeanne Flavin, *The Policy and Politics of Reproductive Health Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications for Women's Legal Status and Public Health*, J. HEALTH POL'Y, POL. & L. 299, 318 (2013) ("In cases where a harm was alleged (e.g., a stillbirth), we found numerous instances in which cases proceeded without any evidence, much less scientific evidence, establishing a causal link between the harm and the pregnant woman's alleged action or inaction.")

A. *Parents' Constitutional Right to Make Medical Decisions for Their Children*

Parents' interest in the care, custody, and control of their children is among the most venerable and longstanding of the liberty interests that the Supreme Court has deemed protected by the Constitution. Almost a century ago, in the case of *Pierce v. Society of Sisters*, the Court overturned a state statute on the ground that it "unreasonably interfere[d] with the liberty of parents . . . to direct the upbringing and education of [their] children."¹¹¹ In the Court's words,

The fundamental theory of liberty . . . excludes any general power of the state to standardize its children The child is not the mere creature of the state; those who nurture him and direct his destiny have the right, coupled with the high duty, to recognize and prepare him for additional obligations.¹¹²

The Supreme Court more recently reaffirmed parents' decision-making rights for their children in the case of *Troxel v. Granville*.¹¹³ In it, the Court struck down a Washington State statute that a trial court had relied on to grant grandparents visitation with their grandchildren over the mother's objection.¹¹⁴ In Justice O'Connor's words,

so long as a parent adequately cares for his or her children (*i.e.*, is fit), there will normally be no reason for the State to inject itself into the private realm of the family to further question the ability of that parent to make the best decisions concerning the rearing of that parent's children.¹¹⁵

In words that have great import when applied to the MCA issue, the Court stated, "the Due Process Clause does not permit a State to infringe on the fundamental right of parents to make child rearing decisions simply because a state judge believes a 'better' decision could be made."¹¹⁶

Parents' right to make childrearing decisions encompasses decision making regarding their children's health care.¹¹⁷ Fur-

¹¹¹ *Pierce v. Soc'y of Sisters*, 268 U.S. 510, 534 (1925).

¹¹² *Id.* at 535.

¹¹³ *Troxel v. Granville*, 530 U.S. 57, 57 (2000).

¹¹⁴ *Id.* at 57-58.

¹¹⁵ *Id.* at 68-69.

¹¹⁶ *Id.* at 72-73.

¹¹⁷ *Parham v. J.R.*, 442 U.S. 584, 602 (1979).

ther, the presumption that fit parents act in the best interests of their children also extends to medical decision making.¹¹⁸ Both the right and the presumption are based, not on the view that parent's "own" their children and therefore have the right to control them, but instead, in the Supreme Court's words, on the view that the "natural bonds of affection lead parents to act in the best interests of their children."¹¹⁹ As Professor Joseph Goldstein noted:

As *parens patriae* the state is too crude an instrument to become an adequate substitute for parents. . . . It does not have the capacity to deal on an individual basis with the consequences of its decisions or to act with the deliberate speed required by a child's sense of time and essential to his well being.¹²⁰

Parents' right to determine children's medical care is not, of course, absolute.¹²¹ Under the doctrine of *parens patriae*, the state has a right and indeed a duty to protect children. Yet it is only when a parent, through action or inaction fails to provide the minimum degree of acceptable parenting, and therefore commits abuse or neglect, that the state is permitted to exercise its *parens patriae* protective role.¹²² As the next section shows, the situations that authorize government intervention in medical decision making are supposed to be the exceptions rather than the rule, however.

B. *Parents' Constitutional Rights in Established Medical Neglect Case Law*

As Professor Goldstein observed decades ago, the boundary between parents' medical decision-making rights and the state's right to intervene based on dependency law is one dangerously vulnerable to incursion through the vague prohibitions of abuse and neglect encoded in state statutes.¹²³ Until MCA was concep-

¹¹⁸ *Id.*

¹¹⁹ *Id.* at 603 (citing 1 W. Blackstone, Commentaries *447; 2 J. Kent, Commentaries on American Law *190.).

¹²⁰ Goldstein, *supra* note 3, at 650.

¹²¹ *Parham*, 442 U.S. at 604.

¹²² *Prince v. Massachusetts*, 321 U.S. 158 (1944); *Newmark v. Williams*, 588 A.2d 1108, 1110 (Del. 1991); *Custody of a Minor*, 393 N.E. 836, 843-44 (Mass. 1979); *In re Application of L.I. Jewish Med. Ctr.*, 557 N.Y.S.2d 239, 243 (N.Y. Sup. Ct. 1990); *In re Willmann*, 493 N.E.2d 1380, 1388-89 (Ohio 1986).

¹²³ Goldstein, *supra* note 3, at 650-51.

tualized, the only cases that had tested the line between parents' medical decision-making authority and the state's right to intervene to protect children were medical neglect cases. In these cases, doctors asserted that parents were depriving children of appropriate treatment—in other words, undertreating them, in contrast to the MCA cases' assertions of overtreatment. In response to these claims, courts carefully drew the line circumscribing state intervention in order to provide robust protection to parents' rights while still safeguarding children's wellbeing.

The limits that courts have traditionally imposed on government intervention in medical neglect cases are instructive in the MCA context. Courts declared that “[s]tate intervention . . . is only justifiable under compelling conditions.”¹²⁴ While different courts phrased the legal tests to ascertain the presence of such compelling conditions in slightly different ways, at their core, they authorize intervention only when three circumstances are present. First, the state's preferred course of treatment must be compelling in the sense that all the child's medical doctors agree that it is the correct one.¹²⁵ Second, the state's preferred course of treatment must be both likely to result in great benefit and to pose few countervailing risks to the child.¹²⁶ Third, the threat to the child's health from forgoing the treatment must be significant.¹²⁷ Under these standards, for example, courts generally authorize blood transfusions when doctors agree that a child's life is at stake but the parent refuses such treatment based on religious reasons.¹²⁸ Likewise, courts will override the decision of a parent

¹²⁴ *Newmark*, 588 A.2d at 1117.

¹²⁵ *See, e.g., In re Storar*, 420 N.E.2d 64, 73 (N.Y. 1981); *In re Hofbauer*, 393 N.E.2d 1009, 1014 (N.Y. 1979); *Custody of a Minor*, 393 N.E. at 846.

¹²⁶ *See, e.g., Newmark*, 588 A.2d at 1117-18; Goldstein, *supra* note 3, at 653; *see also In re Burns*, 519 A.2d 638, 645 (Del. 1986).

¹²⁷ *See, e.g., In re D.L.E.*, 645 P.2d 271, 275-77 (Colo. 1982) (en banc); *Muhlenberg Hosp. v. Patterson*, 320 A.2d 518, 521 (N.J. Super. Ct. Law Div. 1974); *In re Green*, 292 A.2d 387, 390-93 (Pa. 1972).

¹²⁸ *See, e.g., Jehovah's Witnesses v. King Cnty. Hosp. Unit No. 1*, 278 F. Supp. 488 (W.D. Wash. 1967), *aff'd per curiam*, 390 U.S. 598 (1968); *People ex rel. Wallace v. Labrenz*, 104 N.E.2d 769 (Ill. 1952); *In re Guardianship of L.S. & H.S.*, 87 P.3d 521 (Nev. 2004); *John F. Kennedy Mem'l Hosp. v. Heston*, 279 A.2d 670 (N.J. 1971), *rev'd on other grounds, In re Conroy*, 486 A.2d 1209 (N.J. 1985); *In re Cabrera*, 552 A.2d 1114 (Pa. Super. Ct. 1989).

who refuses clearly-warranted medical treatment for no good reason when death is the likely consequence.¹²⁹

By contrast, courts refuse intervention when physicians disagree among themselves. For example, in the case of *In re Hofbauer*, the New York Court of Appeals refused to declare a child with Hodgkin's disease a neglected child although his parents declined the standard treatment of radiation and chemotherapy, instead placing him on nutritional therapy and injections of laetrile.¹³⁰ Despite the unconventionality of the parent's preferred treatment, the court held that the decision was within the parents' rights since a licensed physician was administering their chosen treatment.¹³¹ According to the court, "great deference must be accorded a parent's choice as to the mode of medical treatment to be undertaken and the physician selected to administer the same."¹³² The court continued:

[T]he most significant factor in determining whether a child is being deprived of adequate medical care, and, thus, a neglected child within the meaning of that statute, is whether the parents have provided an acceptable course of medical treatment for their child in light of all the surrounding circumstances. This inquiry cannot be posed in terms of whether the parent has made a "right" or a "wrong" decision, for the present state of the practice of medicine, despite its vast advances, very seldom permits such definitive conclusions. Nor can a court assume the role of a surrogate parent and establish as the objective criteria with which to evaluate a parent's decision its own judgment as to the exact method or degree of medical treatment which should be provided, for such standard is fraught with subjectivity. Rather, in our view, the court's inquiry should be whether the parents . . . have provided for their child a treatment which is recommended by their physician and which has not been totally rejected by all responsible medical authority.¹³³

The reason for the rule requiring agreement among doctors is straightforward. In Professor Goldstein's words:

¹²⁹ See, e.g., *In re Vasko*, 263 N.Y.S. 552 (N.Y. App. Div. 1933).

¹³⁰ *Hofbauer*, 393 N.E. 2d at 1014-15.

¹³¹ *Id.* at 1014.

¹³² *Id.* at 1013.

¹³³ *Id.* at 1014; see also *Storar*, 420 N.E.2d at 73 ("Of course it is not for the courts to determine the most 'effective' treatment when the parents have chosen among reasonable alternatives."); *id.* at 69 n.3 ("[A]s a matter of public policy a medical facility generally has no responsibility or right to supervise or interfere with the course of treatments recommended by the patient's private physician, even when the patient is incapable of consent due to age.").

No one has a greater right or responsibility and no one can be presumed to be in a better position, and thus better equipped, than a child's parents to decide what course to pursue if the medical experts cannot agree Put somewhat more starkly, how can parents in such situations give the wrong answer since there is no way of knowing the right answer? In these circumstances[,] the law's guarantee of freedom of belief becomes meaningful and the right to act on that belief as an autonomous parent becomes operative within the privacy of one's family.¹³⁴

By the same token, Massachusetts' highest court authorized state intervention to administer chemotherapy for a child's cancer only because all the child's doctors agreed to the treatment.¹³⁵ In the court's words, "[u]nder our free and constitutional government, it is only under serious provocation that we permit interference by the State with parental rights. That provocation is clear here."¹³⁶

On the same rationale, courts refuse to intervene in medical neglect cases when the state's proposed course of treatment presents significant risks to a child or lacks a high chance of success, even where a child's life is threatened by the absence of this treatment. For example, the Supreme Court of Delaware refused to order that a child receive a novel form of chemotherapy because the "proposed medical treatment was highly invasive, painful, involved terrible temporary and potentially permanent side effects, posed an unacceptably low [40%] chance of success, and a high risk that the treatment itself would cause his death."¹³⁷ These factors, the court held, undercut the compelling conditions necessary to "outweigh the parental prerogative."¹³⁸ Concomitantly, courts that have authorized medical treatment over a parent's objection have noted that intervention would be inappropriate if the treatment was inherently dangerous or invasive, or reasonable persons could disagree about whether the child's life after the intervention would be worth living.¹³⁹

¹³⁴ Goldstein, *supra* note 3, at 654-55.

¹³⁵ See *Custody of a Minor*, 393 N.E. at 846.

¹³⁶ *Id.*

¹³⁷ *Newmark v. Williams*, 588 A.2d 1108, 1118 (Del. 1991).

¹³⁸ *Id.*; see also *In re Phillip B.*, 156 Cal. Rptr. 48, 52 (Ct. App. 1979) (refusing a state's request to repair a child's heart defect over the parents' objection based on the risks posed by the surgery).

¹³⁹ See, e.g., *People ex rel. Wallace v. Labrenz*, 104 N.E.2d 769, 773 (Ill. 1952) (noting the low risk associated with blood transfusion); *Muhlenberg*

C. *The Broad Definition of Medical Child Abuse and Medical Neglect Safeguards*

The broad definition of MCA developed by physicians undercuts the careful balance between parent and state that courts have constructed in past medical neglect cases. In these cases, courts have denied intervention when physicians disagree about a medical plan. In stark contrast, MCA allows physicians to declare abuse whenever they disagree with the medical care that a child has received, even when another doctor ordered it and still supports that care. And unlike medical neglect, with MCA, when physicians disagree about a child's diagnosis and therefore the child's care plan, and a parent chooses between these physicians, a physician can declare abuse despite the absence of any compelling reason for the court to choose one side over the other.¹⁴⁰ Likewise, the MCA definition does not exclude situations in which the benefits and risks of particular treatments are unclear, or in which the doctor and the parent weigh these pluses and minuses differently. Finally, medical neglect doctrine does not authorize intervention to stop parents from seeking other physicians' opinions when a parent believes a child is not yet correctly diagnosed, although the MCA definition would call such behavior "abuse." Of course, physicians may choose to adopt any set of decision-making rules they want, including those that accord parents no deference whatsoever, as unwise and un-American as such a set of rules may be. But for courts to accept physicians'

Hosp. v. Patterson, 320 A.2d 518, 521 (N.J. Super. Ct. Law Div. 1974) (stating "if the disputed procedure involved a significant danger to the infant, the parents' wishes would be respected"); State v. Perricone, 181 A.2d 751, 760 (N.J. 1962) (declaring the parents would have a strong argument that they should make the decision if "there were substantial evidence that the treatment itself posed a significant danger to the infant's life").

¹⁴⁰ In the words of one judge properly concerned about this issue in an MCA case, to be sufficient to establish abuse:

the conflict in evidence before the trial court has to be more than physicians disagreeing over whether the prior diagnoses of and treatment plans for the children were correct. Rather, the conflict must be whether those diagnoses and treatment plans in part were based on voluntary misreporting of symptoms by parents to meet their own psychological needs.

Frank D. v. Ariz. Dep't of Econ. Sec., No. 1 CA-JV 11-0017, 2011 WL 3300669, at *5 (Ariz. Ct. App. Aug. 2, 2011) (Norris, J. concurring).

determination and to put the force of government intervention behind these rules, as courts have been doing, grossly violates our constitutional scheme.

Justina Pelletier's case, described in the introduction, provides a clear example of how MCA charges breach parents' constitutional rights.¹⁴¹ The state's intervention in that case was justified by the charges of abuse made against her parents. Yet those abuse charges turned on a dispute between physicians over Justina's correct diagnosis. When doctors disagree, however, it is properly the role of parents, not the state, to make these tough medical decisions on behalf of their children.¹⁴² Furthermore, as fit parents, the Pelletiers' decision was entitled to the presumption that it served the child's best interests.¹⁴³ Recall the words of the New York Court of Appeals in *Hofbauer* that the state may not "assume the role of a surrogate parent and establish as the objective criteria with which to evaluate a parent's decision its own judgment as to the exact method or degree of medical treatment which should be provided, for such standard is fraught with subjectivity."¹⁴⁴ The state's forcible intrusion into the Pelletiers' decision-making, and its taking sides on which doctor's opinion to accept, placed the state in precisely the role of surrogate parent forbidden by the Constitution.

Indeed, the *Pelletier* case shows exactly why such governmental intervention generally disserves the best interests of children, even if physicians and state officials act with the best of intentions. When two sets of physicians fundamentally disagree about diagnosis and treatment, the decision maker best positioned to resolve the conflict is generally not a court or child protection official who has spent little to no time with the child. Instead, it is the parent who knows the child best, is most motivated to ensure their welfare, and who has seen the child's medical issues develop over time. In Justina's case, in the face of

¹⁴¹ See Swidey & Wen, *supra* note 5; Swidey & Wen, *supra* note 14; Swidey & Wen, *supra* note 8.

¹⁴² See *Custody of a Minor*, 393 N.E. at 846; *Storar*, 420 N.E.2d at 73; *Hofbauer*, 393 N.E.2d at 1013-14; see also Goldstein, *supra* note 3, at 652 (the state may overcome a presumption of parental autonomy in health-care matters only when "the medical profession is in agreement about what non-experimental medical treatment is right for the child.").

¹⁴³ See *Troxel*, 530 U.S. at 69.

¹⁴⁴ *Hofbauer*, 393 N.E.2d at 1014.

diametrically conflicting medical opinions, the best decision makers were her parents.¹⁴⁵

While proponents of the MCA theory use the fact that a few parents have intentionally used the medical system to abuse children in order to cast suspicion on all parents who disagree with a doctor's care plan, this rare abuse does not justify the wholesale scrutiny of medical decisions by parents of children with complex medical issues. As the Supreme Court recognized, "[t]hat some parents 'may at times be acting against the interests of their children' creates a basis for caution, but is hardly a reason to discard wholesale those pages of human experience that teach that parents generally do act in the child's best interests."¹⁴⁶ Further, "[s]imply because the decision of a parent . . . involves risks does not automatically transfer the power to make that decision from the parents to some agency or officer of the state."¹⁴⁷ The failure of the MCA theory to accord appropriate deference to parents' decisions regarding their children's medical care renders it unconstitutional and bars it use in court.

D. "Medical Child Abuse" and the Legal Test for Child Abuse

The fact that physicians call their determination "medical child abuse," and portray their determination as demonstrating legal child abuse, does not authorize government intervention. That is because, as described below, the MCA conceptualization is far broader than legal standards for child abuse in three important ways. First, the medical standards do not require any particular showing of blameworthiness on the part of the parent, in contrast to the legal definition of abuse. Second, abuse law demands, at the very least, some significant level of risk to the child, while MCA standards impose liability when a parent subjects the child to any degree of potential risk. Third, the medical standard

¹⁴⁵ Justina Pelletier's parents later filed a civil action against Boston Children's Hospital claiming that the hospital and four pediatric specialists had committed medical malpractice in its treatment of the Justina. A jury ultimately found in favor of the hospital. Tonya Alanez, *Justina Pelletier's Family Loses Their Civil Suit Against Boston Children's Hospital*, BOS. GLOBE (Feb. 20, 2020), <https://www.bostonglobe.com/2020/02/20/metro/boston-childrens-hospital-not-negligent-justina-pelletier-civil-trial/#bgmp-comments>.

¹⁴⁶ *Parham v. J.R.*, 442 U.S. 584, 602-603 (1979) (citations omitted).

¹⁴⁷ *Id.* at 603.

that physicians use to “diagnose” MCA allows a more lenient standard of proof than the law requires.

1. *Blameworthiness of the Parent*

MCA-charge proponents make clear that a parent’s culpable intent is not required to diagnose MCA. As Dr. Jenny and Dr. Roesler put it, MCA “occurs when a child receives unnecessary and harmful or potentially harmful medical care at the instigation of a caretaker . . . [W]ith this definition it is not necessary to determine the parent’s motivation to know that a child is being harmed.”¹⁴⁸ Yet this standard omits the critical showing of blameworthiness required by law to find child abuse.

As our legal system has long recognized, parents will never be perfect, and sometimes—probably often—will make mistakes. These mistakes do not constitute child abuse, even if they lead to the child’s injury, unless they are accompanied by a level of blameworthiness that exceeds simple negligence on the part of the parent. Requiring more than negligence when a child is injured, in the words of the New Jersey Supreme Court, “reflect[s] a compromise between a parent’s right to raise a child as he sees fit and the child’s right to receive protection from injuries.”¹⁴⁹ The Maryland Supreme Court explored the level of culpability required to find child abuse in a civil dependency proceeding in the case of *Taylor v. Harford County Department of Social Services*.¹⁵⁰ In the court below, an administrative law judge had found abuse by a father based on his intentionally kicking a footstool in anger, which inadvertently hit and injured his daugh-

¹⁴⁸ ROESLER & JENNY, *supra* note 31, at 43-44; *see also* 2013 AAP Report, *supra* note 46, at 591 (“The term ‘fabricated illness in a child’ has been used in this report to reflect the emphasis on the child as the victim of the abuse rather than on the mental status or motivation of the caregiver who has caused the signs and/or symptoms. . . . [T]he definition and diagnosis of caregiver-fabricated illness in a child should focus on the child’s exposure to risk and harm and associated injuries or impairment rather than the motivation of the offender. Caregiver-fabricated illness in a child is best defined as maltreatment that occurs when a child has received unnecessary and harmful or potentially harmful medical care because of the caregiver’s fabricated claims or signs and symptoms induced by the caregiver.”).

¹⁴⁹ *G.S. v. Dep’t of Hum. Servs.*, 723 A.2d 612, 620-21 (N.J. 1999).

¹⁵⁰ *Taylor v. Harford Cty. Dep’t of Soc. Servs.*, 862 A.2d 1026, 1035-37 (Md. 2004).

ter.¹⁵¹ The Maryland Supreme Court reversed on the ground that considering any intentional act that resulted in harm to the child to be “child abuse” would:

basically creat[e] a strict liability standard for parents or caretakers who unintentionally injure their children. We consider, for example, . . . a father . . . swinging a hammer while nailing together pieces of a partition wall and does not notice that his child has walked up behind him. The father swings the hammer backwards and strikes the child in the face, causing significant injury. Under the ALJ’s reading . . ., because the act of swinging the hammer back before striking a nail was an intentional act and not “accidental or unintentional,” and his child was injured because of this intentional act, the father might be found to have committed child physical abuse. We doubt that [the statutory scheme] intends for such a draconian strict liability standard.¹⁵²

Instead, the court held that the parent’s act must at least be “reckless,” meaning “[c]haracterized by the creation of a substantial and unjustifiable risk of harm to others and by a conscious (and sometimes deliberate) disregard for or indifference to that risk” to constitute abuse.¹⁵³ Reckless conduct, the court declared, “is much more than mere negligence: it is a gross deviation from what a reasonable person would do.”¹⁵⁴

Many if not most of the range of acts that could be deemed MCA by physicians would not rise to the standard of culpability needed for child abuse. For example, it is doubtful that the parent who takes a child to the doctor too often as a result of a previous health crisis would be deemed negligent, let alone reckless. The same is likely true for parents who inadvertently misstate their child’s medical history, particularly given, as shown in Part III, that a large number of parents routinely misstate their child’s medical history outside of the medical child abuse context.¹⁵⁵ Further, in a case like Justina Pelletier’s, where doctors were split on their views of the child’s proper diagnosis,¹⁵⁶ the state would have been hard pressed to show that her parents’

¹⁵¹ *Id.* at 1029-30.

¹⁵² *Id.* at 1036.

¹⁵³ *Id.* at 1033 (citations omitted).

¹⁵⁴ *Id.* (citation omitted); *see also* *G.S.*, 723 A.2d at 620-21 (recognizing that the wanton and willful standard “reflect[s] a compromise between a parent’s right to raise a child . . . and the child’s right to receive protection from injuries”).

¹⁵⁵ *See infra* Part III.

¹⁵⁶ *See supra* notes 11-18 and accompanying text.

actions in choosing one doctor's views over another constituted negligent, let alone reckless, behavior.

2. *Unreasonable Risk to the Child*

The standards for diagnosing MCA also go well beyond the legal definition of child abuse by imposing liability on a parent who exposes a child to *any* potential risk of harm, no matter how remote. MCA proponents claim that “[a]ny medical procedure, for example, a blood draw, or a trial of medication that is potentially harmful, could be considered abusive if there was no clear medical reason for it to happen.”¹⁵⁷ Yet courts have made clear that when a parent did not intend harm, the child must be subjected to a significant, actual risk of harm to constitute abuse.¹⁵⁸ Some states frame this standard as requiring at least a “substantial” or “serious” risk of harm.¹⁵⁹ Others require that the harm be “imminent” or “immediate.”¹⁶⁰

Neither of these tests would be met by the far more speculative harms deemed to meet MCA standards. For example, Jenny and Roesler state that in their MCA study, the “most common form of abusive behavior was subjecting children to unnecessary medical examinations.”¹⁶¹ Yet most medical examinations present an extremely small risk of harm to the child. The same is true for many noninvasive tests, as well as a number of relatively benign medications. Accordingly, these would not rise to the level of risk that would constitute child abuse under applicable state law.

¹⁵⁷ Isaac & Roesler, *supra* note 54, at 291.

¹⁵⁸ See *In re Soram*, 25 I. & N. Dec. 378, 382 (BIA 2010) (noting that, with respect to states' civil definitions of child abuse, in Pennsylvania, Tennessee, and Wyoming, the threat of harm must be quite high, requiring that the child be placed in “imminent” or “immediate” danger of injury or harm, while “the remaining States use various terms to describe the level of threat required, including ‘realistic,’ ‘serious,’ ‘reasonably foreseeable,’ ‘substantial,’ or ‘genuine’”); see also *State v. Chavez*, 211 P.3d 891, 897 (N.M. 2009) (holding that child abuse statute's purpose was to “punish conduct that creates a truly significant risk of serious harm to children.”).

¹⁵⁹ See *Soram*, 25 I. & N. Dec. at 382; see, e.g., *Chavez*, 211 P.3d at 897; see also *State v. Burdine-Justice*, 709 N.E.2d 551, 555 (Ohio Ct. App. 1998).

¹⁶⁰ See *Soram*, 25 I. & N. Dec. at 382; see also *Hernandez v. State*, 531 S.W.3d 359, 363 (Tex. App. 2017) (holding that the child must be placed in “imminent danger of death, bodily injury, or physical or mental impairment.”).

¹⁶¹ ROESLER & JENNY, *supra* note 31, at 146.

3. Standard of Proof

Even if the methods that CAPs used to “diagnose” MCA were reliable, the standard of proof they use to make their decisions falls short of the heightened standard that every state requires to show child abuse at some point in a civil or criminal proceeding. When it comes to the initial adjudication of child abuse in civil dependency proceedings, states are divided on the requisite standard of proof. Many use a standard of “clear and convincing evidence,”¹⁶² while others use a lower “preponderance of the evidence” standard.¹⁶³ Later, at the termination of parental rights stage, all states use, at the minimum, a “clear and convincing evidence” standard of proof.¹⁶⁴ In a criminal child abuse proceeding the standard of proof is still higher: “beyond a reasonable doubt.”¹⁶⁵ Yet although the centerpiece of evidence of abuse in an MCA case is the doctor’s “diagnosis” of MCA, the diagnostic standards used by doctors incorporate no such heightened standards of proof.

¹⁶² See, e.g., *M.G. v. Madison Cnty. Dep’t of Hum. Res.*, 248 So. 3d 13, 16 (Ala. Civ. App. 2017); *In re A.W.*, 797 S.E.2d 655, 658 (Ga. Ct. App. 2017); *In re Delaney*, 185 N.W.2d 726, 728 (Iowa 1971); *In re B.D.-Y.*, 187 P.3d 594, 598 (Kan. 2008); *State in Interest of Gray*, 353 So. 2d 393, 394 (La. Ct. App. 1977); *Care and Protection of Laura*, 610 N.E.2d 934, 937 (Mass. 1993); *In re V.R.*, 355 N.W.2d 426, 431 (Minn. Ct. App. 1984); *In re G.C.*, 50 S.W.3d 408, 410 (Mo. Ct. App. 2001); *ex rel. Children, Youth & Families Dep’t v. Michael H.*, 417 P.3d 1130, 1136 (N.M. Ct. App. 2017); *In re N.K. & D.K.*, 851 S.E.2d 389, 392 (N.C. Ct. App. 2020); *In re J.B.*, 916 N.W.2d 787, 790 (N.D. 2018); *In re L.S.*, 60 N.E.3d 9, 18 (Ohio Ct. App. 2016); *In re A.C.*, 237 A.3d 553, 563, (Pa. Super. Ct. 2020); *In re Jermaine H.*, 9 A.3d 1227, 1231 (R.I. 2010); *In re J.A.H.*, 502 N.W.2d 120, 123 (S.D. 1993); *In re S.J.*, 387 S.W.3d 576, 587 (Tenn. Ct. App. 2012); *State ex rel. N.K.C.*, 995 P.2d 1, 3 (Utah Ct. App. 1999); *State v. Thornton*, 720 S.E.2d 572, 586 (W. Va. 2011); *In re Lauren F.*, 533 N.W.2d 812, 818 (Wis. 1995).

¹⁶³ See, e.g., ALASKA STAT. ANN. § 47.10.011 (2021); *In re Izabella M.*, Nos. T11CP12014147, T11CP12014148, 2013 WL 453067 (Conn. Super. Ct. 2013); *In re Brandon L.*, Nos. 1–15–0779, 1–15–0944, 2015 WL 5254431 (Ill. App. Ct. 2015); *Greysen G. v Liz C.*, 61 Misc. 3d 1216(A), 110 N.Y.S.3d 893, (N.Y. Fam. Ct., 2018); *In re L.A.T.-J.*, 12 Wash. App. 2d 1038, No. 80254-2-I, 2020 WL 2026087 (Wash. App. Ct. 2020).

¹⁶⁴ That standard was required by the U.S. Supreme Court in *Santosky v. Kramer*, 455 U.S. 745, 747-49 (1982). One state, New Hampshire, uses a higher standard of proof, “beyond a reasonable doubt.” *In re Jessica B.*, 429 A.2d 320, 322 (N.H. 1981).

¹⁶⁵ See, e.g., *State v. Consaul*, 332 P.3d 850, 865 (N.M. 2014).

The New Mexico Supreme Court in *State v. Consaul* reversed a defendant's criminal conviction of child abuse because the heart of the prosecution's case turned on expert testimony that a child's injuries were caused by suffocation.¹⁶⁶ In the court's words,

doctors usually testify as to what caused a patient's condition using phrases like "to a reasonable medical probability" or "to a reasonable medical certainty," phrases that demonstrate a sufficient degree of conviction to be probative. These phrases "are also terms of art in the law that have no analog for a practicing physician." Essentially, these phrases satisfy a minimal standard of probability, and therefore admissibility, that an opinion is more likely than not true.

In a criminal trial, however, unlike a medical differential diagnosis, the jury must determine beyond a reasonable doubt that a defendant is guilty of the crime charged. The jury must have a sufficient evidentiary basis to conclude that the defendant actually committed the criminal act he is accused of . . . Essentially, the doctors in this case testified in various ways, and with various degrees of conviction, that they suspected child abuse, that they could not rule out child abuse, that they could not think of other explanations for Jack's injuries, or that child abuse was a likely cause . . . The best these opinions could offer was that, to a preponderance of the evidence, [the child] was likely suffocated.¹⁶⁷

Accordingly, the court held, the evidence presented in the case was not sufficient to establish proof of child abuse beyond a reasonable doubt, the standard required for a criminal conviction.¹⁶⁸ The same situation arises in cases of MCA "diagnoses"

¹⁶⁶ Because the defendant's attorney did not object to the admission of the testimony at trial, the court explicitly did not address the issue of admissibility rather than the weight to be given the testimony. *Id.* at 862.

¹⁶⁷ *Id.* at 865 (quoting JOHN B. WONG, ET AL., Federal Judicial Center, Reference Manual on Scientific Evidence, Reference Guide on Medical Testimony 687, 691 n.9 (3d ed.2011); citing *Renfro v. San Juan Hosp.*, 403 P.2d 68, ¶ 9 (N.M. 1965).

¹⁶⁸ *Consaul*, 332 P.3d at 866. In a footnote, the *Consaul* court noted that the same issue arose with respect to pediatricians' testimony in SBS cases, which had been called into question as unscientific in recent years:

Shaken baby syndrome (SBS) cases may provide a reasonable analogy because medical testimony comprises the foundation of the prosecution's theory in many of these cases. In SBS cases, scholars and advocates for the wrongly convicted have begun to question whether testimony from medical experts that is used to establish a "triad" of indicators of SBS by itself is enough to establish beyond a reasonable

by medical experts. Insofar as such “diagnoses” are the centerpiece of the state’s case that the parent has committed child abuse, as they almost always are, that evidence is not sufficient to prove civil child abuse in those states that require a clear and convincing evidence standard, and is not sufficient to terminate parental rights in any state. Neither does it suffice to establish criminal child abuse beyond a reasonable doubt.

Under the doctrine of *parens patriae*, the state may intervene in parents’ health care decisions only when their behavior constitutes abuse or neglect, as legally defined.¹⁶⁹ The fact that an MCA “diagnosis” does not reflect a determination that child abuse has occurred means that it cannot, as a constitutional matter, warrant intervention in parents’ health care decisions for their children. Simply because a group of physicians has constructed a broad, new conceptualization that covers virtually any case in which they disagree with the medical care provided and has labeled their new construction “medical child abuse,” despite its having little to do with legal child abuse, does not change this constitutional calculus.

III. The “Diagnostic” Process for Medical Child Abuse and Parents’ Constitutional Rights

MCA’s gross intrusion on parents’ constitutional rights is expanded still more by the unreliable process CAPs use to “diagnose” MCA. First developed by Roesler and Jenny, and then adopted by the American Academy of Pediatrics, the “cornerstone” of the MCA evaluation is a detailed review of the child’s

doubt that the accused shook a baby. According to this research, scientific advances now debunk the idea that a “triad of symptoms” could only be caused by a caretaker shaking a baby. More recently, scholars have noted that “[w]here expert testimony is the case, we should be especially wary of the outcomes that result.”

Id. at 866 n.4 (citations omitted) (quoting Deborah Tuerkheimer, *Science-Dependent Prosecution and the Problem of Epistemic Contingency: A Study of Shaken Baby Syndrome*, 62 ALA. L. REV. 513, 564 (2011) (emphasis in original)).

¹⁶⁹ Parham v. J.R., 442 U.S. 584, 604 (1979).

medical records.¹⁷⁰ The “gold standard” for this medical records review is for the CAP to construct a chart summarizing the child’s medical records, and then to analyze the chart in three different ways:¹⁷¹ (1) comparing the parent’s account of the child’s medical history with the other portions of the medical record;¹⁷² (2) considering whether the parents’ account of the child’s signs and symptoms has been objectively verified;¹⁷³ and (3) using the presence of particular, enumerated factors as indications of abuse.¹⁷⁴

While CAPs maintain that this process reliably distinguishes between parents seeking to abuse a child through medical care and parents legitimately trying to get children the medical care they believe they need, there is little to support this assertion except for CAPs’ say-so. Roesler and Jenny concocted their medical record review process for “diagnosing” MCA out of whole cloth, performing no empirical investigation whatsoever to confirm its validity. The only testing that the researchers did of their process was the retrospective evaluation of 115 case files mentioned earlier.¹⁷⁵ That review, though, did not seek to determine whether the method they used *accurately* separated the rare cases of abusive parents from the many cases of parents legitimately seeking care for ill children. Instead, it simply documented that MCA standards identified *far more* than three times as many cases as abusive than the MSBP criteria had.¹⁷⁶ No testing since

¹⁷⁰ 2017 APSAC Taskforce, *supra* note 69, at 12 (“Analysis using the available records is the cornerstone of evaluation of this form of abuse and neglect.”); ROESLER & JENNY, *supra* note 31, at 131-44.

¹⁷¹ 2017 APSAC Taskforce, *supra* note 69, at 12 (“The gold standard medical record analysis requires the creation of a chronological table of nearly every telephone call, office appointment, emergency room visit, pharmacy record, and hospitalization.”).

¹⁷² See 2013 AAP Report, *supra* note 46, at 593 (“An important overall issue to consider is whether the medical history provided by the caregiver matches the history in the medical record and whether the diagnosis reported by the caregiver matches the diagnosis made by the physician.”).

¹⁷³ *Id.* (in record review, CAPs should compare the “reported signs/symptoms as stated by the caregiver” with “objective observations documented by the physician [and nurses]” to assess “[t]he veracity of the claims made by the caregiver . . . for each symptom and sign.”).

¹⁷⁴ *Id.* at 593.

¹⁷⁵ See *supra* notes 58–61 and accompanying text.

¹⁷⁶ ROESLER & JENNY, *supra* note 31, at 142-44.

then has sought to determine the accuracy of the MCA diagnostic process either.¹⁷⁷

In fact, none of the three tests CAPs commonly apply to the medical records review reliably distinguish parents legitimately seeking care from child abusers. When it comes to the first test—comparing the parent’s account of the child’s medical history with other portions of the medical record—a large body of research outside of the MCA context demonstrates that inconsistencies between a parent’s account and the child’s medical records often occur for innocent reasons. To begin with, research shows that ordinary parents outside of the MCA context routinely misstate their child’s medical condition. One survey of parents who took children to the emergency room found that 91.5% of parents stated that their child’s immunizations were up to date, when only 66% of children were actually current. The researchers warned physicians to “use caution in making clinical decisions based on the history given by a caregiver.”¹⁷⁸ Another study found that mothers often provided information inconsistent with their children’s medical records regarding the length of pregnancy and neonatal problems; only half recalled the birth weight accurately. The study concluded that mothers’ accounts of

¹⁷⁷ Testing the reliability of this process would require investigating the conclusions reached by physicians who applied this process to determine the error rate of their determinations. Thus far, only two empirical studies of MCA have ever been conducted. See Mary Greiner et al., *A Preliminary Screening Instrument for Early Detection of Medical Child Abuse*, 3 HOSP. PEDIATRICS 39 (2013); Constance Mash et al., *Development of a Risk-Stratification Tool for Medical Child Abuse in Failure to Thrive*, 128 PEDIATRICS 1467 (Dec. 2011). Neither of these studies, though, tested the accuracy of this process. Instead, both were retrospective studies that compared the records of children subsequently diagnosed with MCA with those diagnosed with certain legitimate medical conditions to determine whether any characteristics distinguished the two groups. The goal of these studies was to use such characteristics to enable earlier identification of cases suspicious for MCA in future cases. These studies provide no evidence that supports the reliability of the chart review process actually used by CAPs in cases like this. Furthermore, for the reasons laid out in Eichner, *Bad Medicine*, *supra* note 26, at 286-87, these studies were constructed in a manner insufficiently sound even to distinguish reliably between the two groups since there was no attempt to verify independently that the children identified as MCA were in fact abused.

¹⁷⁸ See Edwin R. Williams et al., *Immunization Histories Given by Adult Caregivers Accompanying Children 3–36 Months to the Emergency Department*, 23 PEDIATRIC EMERGENCY CARE 285, 285 (2007).

children's objective data are "not necessarily accurate," and that "[l]ess objective data may be recalled even less accurately."¹⁷⁹ Still another study showed that three weeks after their child's birth, mothers' accounts differed from medical records 22% of the time regarding whether their child was jaundiced, 10% of the time regarding whether an electronic fetal monitor had been used, and 11% regarding whether they had a tear of the perineum.¹⁸⁰

Reviews of medical records outside of the MCA context demonstrate that they too are riddled with errors and omissions that would conflict with a parent's accurate account. One study investigating surgeons' accuracy in recording patients' symptoms found that surgeons "often failed to document patients' pain," as well as other symptoms they considered less medically relevant.¹⁸¹ In addition, a study considering the accuracy of electronic medical records demonstrated that 84% of all notes physicians enter directly into such record systems contained at least one documentation error, with an average of eight errors per patient chart.¹⁸² A study comparing parental reports with medical records regarding children's febrile seizures concluded that the significant discrepancies between these two sets of reports are "more likely to reflect underreporting by [the medical records] than over reporting by [parents]."¹⁸³ These studies show

¹⁷⁹ See R. Kim Oates & Douglass Forrest, *Reliability of Mothers' Reports of Birth Data*, 20 J. PEDIATRICS & CHILD HEALTH 185, 185 (1984).

¹⁸⁰ See Daphne Hewson & Adrienne Bennett, *Childbirth Research Data: Medical Records or Women's Reports?*, 125 AM. J. EPIDEMIOLOGY 484, 487 tbl.3 (1987).

¹⁸¹ Ryan Calfee et al., *Surgeon Bias in the Medical Record*, 32 ORTHOPEDICS 732, 732 (2009); see also Holli A. DeVon et al., *Is the Medical Record an Accurate Reflection of Patients' Symptoms During Acute Myocardial Infarction*, 26 W. J. NURSING RES. 547, 547 (2004) ("Clinicians may be recording those symptoms that support the [heart attack] diagnosis and not those perceived to be less relevant. Findings suggest that the medical record is an inaccurate and inadequate source of information about patients' actual experience of [heart attack] symptoms.").

¹⁸² See Charlene R. Weir & Jonathan R. Nebeker, *Critical Issues in an Electronic Documentation System*, AM. MED. INFO. ASS'N ANN. SYMP. PROC. ARCHIVE 786, 787 (2007).

¹⁸³ Bradley K. Ackerson et al., *Agreement Between Medical Record and Parent Report for Evaluation of Childhood Febrile Seizures*, 31 VACCINE 2904, 2907 (2013).

that, in a great number of ordinary cases outside of the MCA context, there will be innocent reasons for discrepancies between a parent's account of the child's medical condition and the medical records. Such discrepancies would be even more likely to arise with children who had a complicated medical condition with extensive medical history—the children generally screened for MCA.

The second test—using the absence of objective evidence supporting the parent's account of the child's signs and symptoms as an indication of MCA—is also an unreliable test to distinguish loving parents from child abusers. The absence of objective evidence can occur for several reasons besides parental fabrication. First, a number of legitimate medical conditions, including migraine, are characterized by symptoms for which there is no objective confirmation.¹⁸⁴ Second, many symptoms and signs of genuine medical conditions are intermittent. These include cyclic vomiting, seizures, syncope (fainting), and apnea.¹⁸⁵

¹⁸⁴ See, e.g., Keiji Fukuda et al., *The Chronic Fatigue Syndrome: A Comprehensive Approach to Its Definition and Study*, 121 ANNALS INTERNAL MED. 953, 953 (1994) (“The chronic fatigue syndrome is a clinically defined condition characterized by severe disabling fatigue and a combination of symptoms that prominently features self-reported impairments in concentration and short-term memory, sleep disturbances, and musculoskeletal pain. . . . No pathognomonic signs or diagnostic tests for this condition have been validated in scientific studies.”); Sheryl Haut et al., *Chronic Disorders with Episodic Manifestations: Focus on Epilepsy and Migraine*, 5 LANCET NEUROLOGY 148, 148–49 (2006) (“If migraine occurs very early in life, it would be difficult to detect since diagnosis relies on reported symptoms.”); Boudewijn Van Houdenhove & Patrick Luyten, *Customizing Treatment of Chronic Fatigue Syndrome and Fibromyalgia: The Role of Perpetuating Factors*, 49 PSYCHOSOMATICS 470, 470 (2008) (“Syndromes characterized by chronic, medically unexplained fatigue, effort- and stress intolerance, and widespread pain are highly prevalent in medicine.”).

¹⁸⁵ See, e.g., David C. Good, *Episodic Neurological Symptoms*, in CLINICAL METHODS 272 (H. Kenneth Walker et al. eds., 3d ed. 1990); Haut et al., *supra* note 184, at 148–49 (2006) (“Neurological chronic disorders with episodic manifestations (CDEM) are characterised by recurrent attacks of nervous system dysfunction with a return to baseline between attacks.”); Jochen Schaefer et al., *Characterisation of Carnitine Palmitoyltransferases in Patients with a Carnitine Palmitoyltransferase Deficiency: Implications for Diagnosis and Therapy*, 62 J. NEUROLOGY, NEUROSURGERY, & PSYCHIATRY 169, 169 (1997) (“Deficiency of CPT-I is a rare disorder and usually presents in infancy with recurrent episodes of hypoketotic hypoglycaemia, which are often triggered by

Doctors routinely accept that such conditions are real in other contexts absent objective verification. Third, current staffing practices mean that medical personnel will often not be in the room to observe intermittent signs and symptoms in children.¹⁸⁶

Finally, the third test for MCA, in which the CAP considers individual factors supposedly indicative of MCA—“(1) use of multiple medical facilities; (2) excessive and/or inappropriate pattern of utilization, including procedures, medications, tests, hospitalizations, and surgeries; [and] (3) a pattern of missed appointments and discharge of the child against medical advice”¹⁸⁷—fares no better at reliably distinguishing abusers from loving parents of children with complex medical conditions. The first factor, use of multiple medical facilities, occurs with some regularity when parents with children who suffer from rare medical conditions that have not yet been correctly diagnosed shuttle them from doctor to doctor before they find a doctor who can properly diagnose them. The Shire Rare Disease Impact Report found that patients with a rare disease reported on average visiting eight separate physicians before receiving a correct diagnosis.¹⁸⁸ These physicians might often be at different institutions. As with other factors in the MCA determination, this factor has not been tested to determine its error rate. However, that rate is

fasting and accompanied by a decreased level of consciousness and hepatomegaly. . . . In young adults, CPT-II deficiency classically causes recurrent episodes of fasting or exercise induced muscle pain, rhabdomyolysis, and paroxysmal myoglobinuria”); Thangam Venkatesan, *Cyclic Vomiting Syndrome Clinical Presentation*, MEDSCAPE (last updated Oct. 31, 2018), <http://emedicine.medscape.com/article/933135-clinical>.

¹⁸⁶ See, e.g., Perri Morgan et al., *Time Spent with Patients by Physicians, Nurse Practitioners, and Physician Assistants in Community Health Centers, 2006–2010*, 2 *HEALTHCARE* 232, 232–37 (2014) (physicians, physician assistants, and nurse practitioners spend an average of 20 minutes with each patient in community health centers); Danielle Ofri, *The Doctor Will See Your Electronic Record Now*, SLATE (Aug. 5, 2013, 12:27 PM), <https://slate.com/technology/2013/08/study-reveals-doctors-are-spending-even-less-time-with-patients.html> (“[M]edical interns spent 40 percent of their day with a computer compared with 12 percent of their day with actual living, breathing patients”); Barbara Yawn et al., *Time Use During Acute and Chronic Illness Visits to a Family Physician*, 20 *FAM. PRAC.* 474, 475 tbl.1 (2003) (finding that primary care physician office visits lasted about 10 minutes).

¹⁸⁷ 2013 AAP Report, *supra* note 46, at 593.

¹⁸⁸ See SHIRE, *supra* note 67, at 10.

likely high given that, even by child abuse pediatricians' own high end of estimates of the prevalence of MCA, there are roughly 2,000 children with a rare disease for every *one* child who has been the victim of MCA.¹⁸⁹ That means that it is overwhelmingly more likely that a child who meets this criterion has a rare, undiagnosed disease for which the parent is taking them to multiple medical providers than that they are a victim of medical child abuse.

The "multiple medical facilities" factor also wrongly identifies the many cases in which a child has a complex medical condition that affects multiple organs, and which are treated by different medical specialties. Among others, this includes mitochondrial disease, which may be treated by a neurologist, cardiologist, and pulmonologist, and Ehlers Danlos Syndrome, which may be treated by a vascular specialist, cardiologist, neurologist, and a pediatric orthopedic surgeon. The total prevalence rates of just these conditions, while lower than the prevalence rate for all rare diseases, is still roughly 28 in 100,000—14 times higher than pediatricians' high-end estimates of the prevalence of medical child abuse.¹⁹⁰ Accordingly, use of this criterion is far more likely to identify a child with one of these conditions than to identify a child who has been medically abused.

Using the second factor—"excessive and/or inappropriate patterns of utilization" of medical care—introduces still more unreliability into the MCA determination because it is a near-textbook example of the fallacy of circular reasoning. The point of using diagnostic criteria in the MCA context should be to aid the physician in distinguishing between two different types of cases that seem suspicious for abuse: (1) cases in which a parent is intentionally abusing their child through excess medical care, and (2) cases that, while seeming suspicious, actually involve a loving

¹⁸⁹ Child abuse pediatricians estimate the rate of children with MCA at approximate 0.5 to 2.0 per 100,000 children younger than sixteen years. See AP-SAC TASKFORCE, *supra* note 69, and *see supra* text accompanying note 77. Meanwhile, it is estimated that up to 8% of the population has a rare disease, and that between 50–75% of rare diseases begin in childhood, so that at least roughly 4% of children have a rare disease. Supriya Bavisetty et al., *Emergence of Pediatric Rare Diseases: Review of Present Policies and Opportunities for Improvement*, 1 RARE DISEASES at *1 (2013).

¹⁹⁰ For prevalence rates of these conditions, see Eichner, *Bad Medicine*, *supra* note 26, at 304-05.

parent seeking medical care out of concern for their child's well-being. Using the factor of "excessive or inappropriate patterns of utilization" does nothing to assist the CAP in distinguishing between these two groups because it requires that the CAP assume an answer to the question of whether the parent has behaved abusively by getting the child too much care. Only by concluding that patterns of medical care usage have been "excessive or inappropriate" will this factor weigh in favor of an MCA determination, yet determining whether this factor is present requires deciding the very question of abuse that the factor's presence is supposed to answer.

A Washington, D.C. case, *In re N.B.-P.*, illustrates the problems with using this factor to diagnose MCA.¹⁹¹ In that case, the parents of a baby who was born ten weeks prematurely and spent a month in the neonatal intensive care unit, took him multiple times to the emergency room of the local hospital for reasons that included excessive gas, vomiting and diarrhea, a fall, and the mother's observing something she believed could be a seizure.¹⁹² The CAP "diagnosed" medical child abuse based on finding a "pattern" of inappropriately seeking medical care.¹⁹³ After a lengthy hearing, however, the court rejected the CAP's determination, concluding, "This is the case of new parents—with a premature newborn baby who was born with multiple medical issues—and a system of doctors and social workers who jumped to conclusions."¹⁹⁴ The court concluded that "these young, first-time parents were on heightened alert due to [the child's] premature birth and serious medical issues." In this situation, the parents "did the best they could do as parents, which often included taking [the child] to be checked out in case there was something seriously wrong with their already sick newborn."¹⁹⁵ The lesson of *In re N.B.-P.*, put simply, is that a diagnostic criterion focused on a "pattern" of excessive or inappropriate medical care has a high risk of producing inaccu-

¹⁹¹ *In re N.B.-P.*, No. 2014 JSF 001448, 2015 WL 4709707 (D.C. Super. Ct. July 30, 2015).

¹⁹² *Id.* at *2-*3.

¹⁹³ *Id.* at *4.

¹⁹⁴ *Id.* at *7.

¹⁹⁵ *Id.* at *7-8.

rate results because, in order to apply it, the CAP must assume the conclusion that the parents behaved inappropriately.

Use of the third factor—a pattern of missed appointments and discharges against medical advice—also increases the unreliability of the MCA determination. While this factor may be present with children who are truly abused, it will also likely be present in many cases in which parents are legitimately seeking care but are incorrectly suspected of MCA. That is because, in many cases in which a physician suspects MCA, she will either inform the parent that she believes the child is not sick or will seek to remove the child's medical treatments. Many parents of children with rare or complex diseases will, at this point, remove their child from the physicians' care through canceling appointments or discharging their child to enable the child to receive the needed care. Use of this factor involves a different type of circular reasoning than that discussed in the last subsection. Here, the problem is that using missed appointments and discharges against medical advice identifies those cases in which physicians suspect medical abuse without helping distinguish between cases in which their suspicions are correct versus those in which they are incorrect.

This third factor may also appear innocently in cases in which a parent believes that a physician has misdiagnosed their child. As the Shire Rare Disease Impact Report shows, the parent will often be right: the average length of time it takes a patient with a rare disease to get an accurate diagnosis is 7.6 years.¹⁹⁶ In the meantime, the parent of such a child may repeatedly discharge the child against medical advice and sometimes cancel upcoming medical appointments, in order to seek new physicians who will properly diagnose their child.

The fact that CAPs center the MCA determination process on a medical records review arguably makes their determinations seem more like a legitimate medical diagnosis, since this review is often a part of the standard differential diagnostic process. Yet as a test of the veracity of the parent's account regarding the child's condition, which is what the MCA determination supposedly turns on, the medical records investigation is grossly unreliable. That is because this focus on medical records excludes, in the

¹⁹⁶ SHIRE, *supra* note 67, at 10.

great bulk of cases, the witnesses with the best opportunity to confirm or disconfirm the parent's account of the child's condition—namely those people who have spent the most time with the child outside of the hospital and doctors' offices, such as home health aides, teachers, and the other parent of the child. The fact that the MCA determination process does not take account of the observations of such witnesses makes it far more likely to reach an erroneous result.

In short, even had the MCA definition correctly targeted a category of cases that constituted legal abuse, the process that physicians use to determine which cases met their definition would still be insufficiently reliable to justify interfering with the constitutional rights of those parents identified. That process cannot reliably identify the few cases in which parents seek medical care for their children for their own twisted ends from the many cases in which loving parents legitimately seek answers and care for children with rare or complex medical conditions.

IV. Recent Encroachment on Parents' Rights in Medical Neglect Cases

Part II of this article suggested that courts in medical abuse cases have improperly failed to apply the longstanding protections of parents' rights that exist in medical neglect cases. This Part raises the troubling possibility that the opposite may be occurring in dependency courts today: judges and lawyers who have become accustomed to accepting the outsized and improper roles that government and physicians are playing in MCA cases may now be transporting these same oversized roles into medical neglect cases, thereby accepting parents' diminished rights to make health-care decisions in these cases as well.

In one recent case, the parents of a young child presented him to a major children's hospital in the northeast for a medical opinion regarding his gastrointestinal issues.¹⁹⁷ A pediatric GI specialist at the hospital diagnosed the child with inflammatory bowel disease (IBD), a condition characterized by chronic inflammation of the gastrointestinal tract. The parents then sought

¹⁹⁷ Because the case is ongoing and the parents fear retaliation by the hospital, they have asked that identifying information be withheld from my account.

a second opinion from a medical expert at another major children's hospital who was less certain of the diagnosis, and who recommended additional tests, which were performed before the child's IBD diagnosis was affirmed. The family also sought a third opinion on diagnosis and treatment with a pediatric gastroenterologist at a general hospital. During this time, the child wound up being treated by physicians at both children's hospitals. In one of the visits to the second children's hospital, two courses of an autoimmune infusion ordered by physicians were administered. The parents, however, stopped the child from receiving the third dose because his condition worsened significantly shortly after he received the second infusion and physicians could not explain his deterioration. Afterwards, the parents consulted yet another expert at another children's hospital closer to home than the hospital at which the child had received his infusions.

Several months later, the parents returned their child to the first children's hospital. The child was hospitalized there that time and a subsequent time when his condition worsened; he was released after treatment both times. In between, the parents also brought the child to numerous outpatient appointments at the hospital. Throughout the child's treatment, on a number of occasions, the parents questioned whether particular procedures were necessary, and they delayed having the child perform at least one set of laboratory tests that were ordered. Further, at the end of one of the hospital admissions, the parents discharged the child from the hospital the evening before he was scheduled to be discharged the following morning; it is disputed whether they did so against medical advice.

In the fall of 2021, the child was again admitted to the first children's hospital because his condition had worsened, where he was started on a new immunosuppressant drug. Shortly afterwards, because of the seriousness of the child's IBD, the GI physician recommended ileostomy surgery, which would result in the child's wastes being diverted into a pouch. The parents spoke to the Family Relations unit at the hospital for assistance in getting a second opinion on the surgery, also contacting one of the GI specialists they had seen before at a different hospital. Based on the child's medical records, that specialist was not convinced that surgery was warranted before other courses of treatment were

attempted. But rather than facilitate the child's transfer to the other hospital to make that second opinion possible, the GI specialist at the children's hospital filed a petition for medical neglect against the parents, based on the parents' questioning and noncompliance with her orders and their taking the child to the physicians at other hospitals. On this petition, a dependency court judge removed custody from the parents on an emergency basis.

Until this point, the relationship between the first children's hospital and the parents had certainly been somewhat contentious. This was a product of the fact that the parents were very active participants in their son's care and often questioned whether and why particular care was necessary, at times consulting other physicians or refusing care when they believed it was not in their son's best interests. Yet in behaving that way, the parents were well within their constitutional rights as medical decisionmakers for their child. In that role, they were entitled—indeed, charged with the weighty responsibility—to ask questions, make objections, and seek the opinion and care of a second, third, even fourth doctor when they were unconvinced by a diagnosis or a proposed course of treatment. They were also entitled to refuse medical treatment they believed was not in their child's best interests.

As laid out in Part II, good law from the high courts of several states establishes that government intervention in a medical neglect case like this one is appropriate only where the parents' actions are clearly wrong in the sense that licensed physicians are all of the same opinion about the proper course of treatment, the child's condition is life-threatening, and there are no significant downsides or risks to the physician's chosen course. It happened that the state in which the dependency petition was filed had no clear case law from appellate courts that explicitly defined the bounds of parents' constitutional rights to make medical decisions in medical neglect cases. Yet there was nothing to suggest that the state's appellate courts would diverge from the clear law governing other states. Under this law, the parents had never overstepped their roles in a manner that would have authorized government intervention. Earlier in the course of the child's illness, physicians at different hospitals had first disagreed regarding the child's diagnosis and later with his course of treatment.

At the time that the parents discharged their son from the hospital a night early, even if they did so against medical advice (a disputed issue), there was no contention that the child's condition was life threatening. And when the parents discontinued their son's infusions they did so based on evidence that it was creating significant medical problems for the child. The Constitution authorizes such conduct, protecting parents from having to defer blindly to physicians.¹⁹⁸ Looking ahead to the proposed surgery, the doctrinal limits on government intervention should have prevented the court from intruding on the parents' decision making. The fact that the GI expert from the general hospital agreed to evaluate the child, as well as his preliminary opinion doubting that surgery was the preferred course for the child meant that not all physicians were on the same page, which should have precluded government intervention. Recall Professor Joseph Goldstein's words that, where there is no clearly correct medical course, in our constitutional scheme, it is parents rather than the courts or physicians, who have the right to make medical decisions for the child.¹⁹⁹

The parents, though, never got the chance to argue that the decision regarding surgery was theirs to make. Instead their attorneys, two veteran parents' lawyers, refused to contest the court's preliminary finding of medical neglect. The physicians in abuse and neglect cases, they told the parents, wielded significant clout. The fact that the parents had not followed their doctors' directives, the lawyers told them, meant that a judge would likely reaffirm the finding of dependency if the parents contested the issue. Further, if the parents contested the physicians on this issue, their attorneys advised, the hospital might retaliate by seeking to have the child permanently removed from the parents. In this case, according to the lawyers, there was a reasonable chance that the parents might lose custody of the child permanently, as had occurred in several medical child abuse cases in the local courts. The parents' attorneys therefore counseled that the parents' only viable strategy was simply to argue that the judge should exercise his discretion in ruling that surgery at that time was the less preferable course for the child – leaving the issue of

¹⁹⁸ See *supra* Part IIA, Part IIB.

¹⁹⁹ Goldstein, *supra* note 3, at 654-55.

the parents' rights to make this determination completely off the table.

It turns out that the views of the parents' attorneys were not outside the bell curve of local practice. When I sought assistance for the parents from a leading state expert in children's rights at a nearby nonprofit clinic, he was astounded to hear me argue that the judge lacked appropriate grounds to resolve the question of surgery in the child's best interests. The physicians from that hospital, he told me, had the best interests of children at heart; when parents sought to reject their advice, it was properly up to the judge to decide what served the child best. Parents' constitutional rights to determine their children's health care played no role in any of these lawyers' analyses. Ultimately, the dependency court judge ordered that it was in the boy's best interests to have the surgery, and the operation was performed over the parents' objections. If what occurred in this case is representative of what is happening in dependency courts in other states, it does not augur well for the future of parents' medical decision-making rights.

V. Protecting Parents' Medical Decision-Making Rights

Our constitutional jurisprudence is grounded on the principle that parents, rather than the state, have the right to the custody and care of their children, including medical decision making. That principle rests on the considered view that parents are best positioned and most motivated to ensure children's wellbeing. The exceptions to this rule occur in cases in which parents neglect or abuse their children. But those exceptions are, in our constitutional system, intended to be rare. Physicians' invention of MCA charges threaten to upend this system, allowing physicians to intervene virtually at will when they disagree with parents. Reasserting parents' decision-making rights in all but the small subset of cases in which neglect or abuse are genuinely threatened is necessary to protect children's wellbeing. Action from legislators and attorneys representing parents can help safeguard parents' rights as well as protect children's wellbeing.

A. Legislative Action to Limit Medical Child Abuse Charges

Several legislative fixes would stymie pediatricians' unconstitutional overreach on MCA. First, state legislatures can pass statutes that, as a substantive matter, clarify the appropriate boundaries between parents' legitimate exercise of their constitutional rights, on the one hand, and genuine child abuse and neglect, on the other. The draft *Restatement of Children and the Law*, passed in tentative form by the American Law Institute, contains helpful language that could be incorporated into state law:

A parent's [health-care] decision is entitled to deference when licensed medical doctors disagree about the diagnosis or appropriate course of treatment and there is substantial medical support for the parent's choice of treatment. There is medical support for the parent's decision when it is based on an acceptable standard of care or practice in the medical profession sufficient to shield the recommending doctor from liability for negligent diagnosis or treatment. If the recommending doctor could not be subject to malpractice liability based on his or her diagnosis or treatment, . . . the parent's selection of the treatment [is within his or her authority] even if it is not recommended by the majority of doctors.²⁰⁰

A later section of the *Restatement* adds that "a parent may choose to seek the opinion of additional licensed medical doctors even if the child's current doctors disagree."²⁰¹ Statutes that make it clear that parents who choose between doctors' opinions

²⁰⁰ RESTATEMENT OF CHILDREN AND THE LAW § 2.30 cmt. a (AM. L. INST., Tentative Draft No. 1, 2018). The Restatement also provides an illustration of this principle of law derived from Justina Pelletier's case, described *supra* notes 11-17 in the introduction:

Jasmine is nine years old and is experiencing severe gastrointestinal pain and low energy that impairs her ability to walk or participate in daily activities. A licensed doctor diagnoses Jasmine with mitochondrial disease, a genetic condition with complex and disputed diagnostic criteria. Another licensed doctor disagrees with the diagnosis of mitochondrial disease and diagnoses Jasmine's symptoms as psychiatric in nature and prescribes inpatient psychiatric care. There is medical support for each of the conflicting diagnoses. Jasmine's parents agree with the first doctor's diagnosis and consent to treat Jasmine for mitochondrial disease. They reject the second doctor's diagnosis and refuse to consent to inpatient psychiatric treatment. A court will defer to the parents' decision.

Id. § 2.30 cmt. c, illus. 11.

²⁰¹ *Id.* § 3.20 cmt. a. at 100.

or who seek more doctors' opinions are exercising constitutional rights rather than committing abuse would go a considerable way toward limiting physicians' attempts to encroach on parents' authority to make such decisions.

Legislatures can also mandate changes in child protective services and court procedures to help ensure that only parents who are truly abusive will face MCA charges. At the child protective services stage, legislators should demand that the agency vigorously investigate reports of MCA rather than simply accepting CAPs' "diagnoses" as conclusive of abuse. The new law passed by Texas in the wake of a series of journalistic exposés concerning the unscientific nature of CAP diagnoses provides a good model for such protections.²⁰² That law requires that once a report of abuse is made, child protective services must refer it for forensic investigation to a healthcare professional other than the one who made the report.²⁰³ (A still-better model would go beyond the Texas act to provide that the forensic investigation be handled by a professional at a different health care facility than the one from which the report of abuse was made.²⁰⁴) In addition, in cases in which legitimate medical conditions could be mistaken for abuse, which will often be the case with MCA charges, the Texas law requires that child protection authorities investigating such a report consult with a specialist in those conditions at the request of parents, the parents' attorneys, or other doctors.²⁰⁵ Child protective services must also consider any opinions of medical professionals offered by the parent.²⁰⁶ The Texas law also prohibits a court from removing the child from the parent's custody on an emergency basis premised on immediate danger to the child's safety solely on the opinion of a medical professional who has not conducted a physical examination of the child.²⁰⁷ Finally, it requires that a court holding a hearing

²⁰² TEX. FAM. CODE ANN. § 261.3017 (West 2021); Mike Hixenbaugh & Keri Blakinger, *New Texas Law Aims to Protect Parents Wrongly Accused of Child Abuse*, NBC NEWS (June 21, 2021, 3:30PM), <https://www.nbcnews.com/news/us-news/new-texas-law-aims-protect-parents-wrongly-accused-child-abuse-n1271646>.

²⁰³ TEX. FAM. CODE ANN. § 261.3017(c-1).

²⁰⁴ *Id.* § 261.3017(c-1)(3).

²⁰⁵ *Id.* § 261.3017(c)-(c-1).

²⁰⁶ *Id.* § 261.3017(e).

²⁰⁷ *Id.* § 262.102(b-1) (West 2021).

following an emergency removal of a child must consider safety opinions from any physicians obtained by the child's parents.²⁰⁸

For those claims of medical abuse that make it to the courtroom, legislatures should also mandate that MCA "diagnoses" be excluded as proof in abuse proceedings. Excluding such diagnoses would require that the government actually meet its burden to prove all the elements of legal abuse, as they are required to do by law, rather than evade this burden by means of diagnostic fiat. The *Restatement of Children and the Law* offers helpful language on this issue:

In cases in which the allegations of physical abuse involve a parent's seeking unnecessary medical treatment for a child, whether the parent's actions constitute physical abuse is a determination to be made by the factfinder. Expert medical testimony may be relevant to factual issues that underlie the determination of physical abuse, including whether the child possessed genuine medical diagnoses, as well as whether the child received unnecessary medical treatment given the child's medical diagnoses.²⁰⁹

The Reporter's Comment to this rule more explicitly explains that "Courts should not admit expert medical testimony regarding the medical child abuse diagnosis."²¹⁰ It then describes the rationale for this rule:

[E]xpert testimony regarding diagnoses properly pertains to the child's bodily conditions. In contrast to traditional medical diagnoses, the determination of medical child abuse is not centered on assessing an underlying bodily condition, but instead represents a determination that the parent's actions in obtaining medical care [f]or a child should be considered physical abuse. . . . Whether the parent's conduct constituted physical abuse is a legal question to be determined by the factfinder.²¹¹

State legislatures should codify similar language to curtail physicians' effort to encroach on parents' constitutional rights through the concocted "diagnosis" of MCA.

²⁰⁸ *Id.* § 262.201(i-1) (West 2021).

²⁰⁹ RESTATEMENT OF CHILDREN AND THE LAW, *supra* note 200, at § 3.20 cmt. k.

²¹⁰ *Id.* § 3.20 reporters' note at 119.

²¹¹ *Id.*

B. *Safeguarding Rights to Medical Decision-Making in Litigation*

With or without legislative changes, parents' attorneys should vigorously seek to enforce parents' rights to medical decision-making in cases in which medical abuse or medical neglect has been charged. To do so, they should raise the issue of parents' constitutional rights directly. They should also seek to exclude admission of MCA "diagnoses" as both a violation of parents' rights and as scientifically unreliable.

1. *Asserting Parents' Constitutional Rights to Make Medical Decisions*

In the courtroom, parents' attorneys should move to dismiss appropriate cases of MCA or medical neglect based on the parent's constitutional right to make medical decisions on behalf of their child. This includes cases in which the charges of abuse or neglect stem from parents' simply choosing between licensed physicians who disagree about the child's diagnosis and care plan, as well as those cases in which a parent believes their child has an undiagnosed condition or disagrees with a physician's care plan and seeks to consult physicians over current physicians' objections. The medical neglect cases described in Part II.B provide useful support for such a motion. Further, the relevant provisions from the forthcoming *Restatement of Children and the Law*, quoted in the previous section on legislative reforms, offer a helpful guide on the proper boundaries of parents' broad authority to make such decisions.

2. *Contesting the Admission of MCA Diagnoses as Legally Improper*

For those cases that reach the stage of a court hearing, parents' attorneys should vigorously press to exclude MCA "diagnoses" from admission into evidence.²¹² Doing so is critical for a parent to get a fair trial on child abuse charges. Opinion testimony by experts has long generated controversy because of "the crucial and often determinative weight an expert's opinion may

²¹² The author of this article has drafted a stock brief in support of such a motion in limine, which she will make available to parents' lawyers on request.

carry.”²¹³ Because of this, courts have carefully sought to cabin the testimony of experts to the area within their legitimate expertise. Accepting MCA as a medical diagnosis to which medical experts may testify makes an end run around these carefully constructed limitations by turning what is properly a legal determination — whether a parent has committed child abuse — into a diagnostic decision (that a child “has MCA”) supposedly within the realm of a physician’s diagnostic expertise.

In denominating MCA as a “diagnosis,” its proponents lump together three separate determinations that, as a conceptual matter, must be made in determining whether MCA occurred in any given case.²¹⁴ First, the child’s genuine underlying medical diagnoses must be determined. Second, it must be decided whether, given these genuine medical conditions, the child received unnecessary, potentially risky medical care. Third, and finally, it must be determined whether, given the first and second inquiries, the parent’s actions rise to the level that she should be held responsible for (in MCA terminology, be deemed to have “instigated”) the unnecessary medical care.²¹⁵ Although MCA proponents treat these three determinations as together comprising the “diagnostic” determination for MCA, in truth, only the first inquiry — which medical diagnoses a child genuinely possesses — constitutes a true diagnostic determination. This is because the term “diagnosis” refers to a process in which the patient’s “signs” (objective phenomena) and “symptoms” (subjective phenomena) are used to determine systematically whether and which abnormal underlying condition or disease the patient has.²¹⁶ Neverthe-

²¹³ *People v. Bowker*, 249 Cal. Rptr. 886, 889 (Cal. Ct. App. 1998).

²¹⁴ *See, e.g.*, 2013 MICH. TASK FORCE REP., *supra* note 71, at 1 (“Medical Child Abuse is a diagnosis recognized and supported by the American Board of Pediatrics.”).

²¹⁵ The 2013 AAP Report recognizes that these determinations are lumped together into the diagnostic determination, although it frames them slightly differently: “1. Are the history, signs, and symptoms of disease credible? 2. Is the child receiving unnecessary and harmful or potentially harmful medical care? 3. If so, who is instigating the evaluations and treatment?” 2013 AAP Report, *supra* note 46, at 593-94.

²¹⁶ “Differential diagnosis” is the process used by physicians to identify and isolate the medical diseases or conditions from which a patient is suffering. *Differential Diagnosis*, DORLAND’S ILLUSTRATED MEDICAL DICTIONARY (31st ed. 2007). In the words of Richard Rogers, an expert in diagnostic and clinical

less, the second inquiry — whether the child has received unnecessary, potentially risky medical care — although not a true diagnostic determination, is still properly admissible on the ground that it is relevant, so long as it is within the expertise of the particular medical expert. In fact, this second inquiry is quite similar to that often performed by experts in medical malpractice cases.²¹⁷

It is expert testimony on the third and ultimate inquiry wrapped up in the MCA determination — whether the parent seeking medical care committed “medical child abuse” by “instigating” the medical care — that has no place in a courtroom of justice. As explained below, there are two separate reasons that admission of such testimony is improper. First, this inquiry involves an assessment of blame, which is properly a legal rather than a diagnostic, or even a medical, consideration. Second, even if MCA were a proper medical diagnosis, a medical expert would still be prohibited from testifying to its presence in a child abuse proceeding since whether the parent has committed child abuse is the ultimate issue before the court. The fact that the MCA “diagnosis” is rendered based on criteria that are far less strict than the legal definition of abuse renders it still more problematic because of its potential to mislead the trier of fact.

a. *The medical child abuse determination and the differential diagnostic process*

In incorporating a determination of whether the parent “instigated” the child’s overtreatment, MCA exceeds the proper scope of a medical diagnosis. This is because the diagnostic inquiry in which physicians are trained involves a search for a particular kind of cause. That diagnostic process consists of using the patient’s “signs” (objective phenomena) and “symptoms” (subjective phenomena) to determine systematically whether and

assessment, “The sine qua non of diagnosis is measurable and reliable differences in signs and symptoms.” Richard Rogers, *Diagnostic, Explanatory, and Detection Models of Munchausen by Proxy: Extrapolations from Malingering and Deception*, 28 CHILD ABUSE & NEGLECT 225, 228 (2004).

²¹⁷ See generally 2 STEVEN E. PEGALIS, AMERICAN LAW OF MEDICAL MALPRACTICE § 8:1 (3d ed. 2016) (“Expert testimony is almost always required in the medical malpractice case to establish the departure from the standard of care and causation.”).

which abnormal underlying condition or disease the patient has.²¹⁸ To take a simple example of a differential diagnosis, when a patient presents with a sore throat, the doctor may investigate whether the symptoms are caused by the bacteria associated with strep throat or, alternatively, by a cold virus. To do so, the doctor will use signs and symptoms, including the patient's temperature, swollen lymph nodes or tonsils, and presence or absence of a cough or headache, as well as laboratory tests, to make an informed judgment — a “diagnosis” — regarding which of these conditions the patient likely has.²¹⁹

This type of diagnostic determination certainly occurs in the first part of the MCA inquiry, when the physician uses the child's signs and symptoms to determine which, if any, genuine diseases or conditions the child truly has.²²⁰ Yet determining whether a parent instigated overtreatment requires an inquiry into causes external to the child's body.²²¹ Courts properly differentiate between such internal and external inquiries of causation by distinguishing between “differential diagnosis” and “differential

²¹⁸ See *supra* note 216.

²¹⁹ One diagnostic protocol for strep indicates, for example, that most sore throats result from a viral infection, rather than the bacterial infection of strep, and then quantifies the percentage of strep cases of all sore throat cases. See Monica G. Kalra et al., *Common Questions About Streptococcal Pharyngitis*, 94 AM. FAM. PHYSICIAN 24, 24 (2016) (“Group A beta-hemolytic streptococcal (GABHS) infection causes 15% to 30% of sore throats in children and 5% to 15% in adults”). The diagnostic protocol then specifies which diagnostic signs and symptoms, such as headache, fever, swollen glands, swollen tonsils, and which laboratory tests, indicate the presence of the bacteria associated with strep, how strong these indicators are, and how often these signs and symptoms are associated with false positive or false negative diagnoses. *Id.* at 24-31.

²²⁰ See *supra* notes 209-211 and accompanying text.

²²¹ Indeed, in transitioning from MSBP to the concept of MCA, Dr. Jenny and Dr. Roesler specifically sought to dismiss the idea that MCA depends on some underlying medical or psychological condition to be diagnosed in the child, in the way that MSBP was believed to have been a diagnosable psychological disorder in the parent. Instead, they argued, doctors should give up the search for an internal condition, and simply identify what happened to the child as child abuse. In response to the question of whether the behavior at the root of the MCA diagnosis is really a syndrome, they answered, “No. The behavior commonly called MSBP is a form of child abuse that takes place in a medical setting. Child abuse is not an illness or a syndrome in the traditional sense but an event that happens in the life of the child.” See, e.g., ROESLER & JENNY, *supra* note 31, at 55.

etiology.”²²² As stated by Dr. Ronald Gots, both types of inquiries “seek to uncover causes, but of very different things.”²²³ Differential diagnosis seeks to identify “the internal disease or process which produces or causes the patient’s symptoms or findings;”²²⁴ meanwhile differential etiology “describe[s] the investigation and reasoning that leads to the determination of external causation.”²²⁵ As the New Mexico Supreme Court observed, “the determination of the external cause of a patient’s disease is a complex process that is unrelated to diagnosis and treatment.”²²⁶

Medical experts’ opinions on etiology are admissible in many types of cases even if they are not accorded as much deference as diagnostic opinions.²²⁷ Yet this is in cases in which medical science sheds light on the physiological process by which a particular medical condition develops, and this science therefore points to factors that may cause the process to occur. Expert testimony in such cases thus serves as the factual predicate to allow the trier of fact to fasten legal liability for a person’s disease or

²²² See *Bowers v. Norfolk S. Corp.*, 537 F. Supp. 2d 1343, 1360 (M.D. Ga. 2007), *aff’d*, 300 F. App’x 700 (11th Cir. 2008) (“The distinction is more than semantic; it involves an important difference.”); *CONSAUL*, 332 P.3d at 863 (quoting Ian S. Spechler, *Physicians at the Gates of Daubert: A Look at the Admissibility of Differential Diagnosis Testimony to Show External Causation in Toxic Tort Litigation*, 26 REV. LITIG. 739, 740 (2007)) (“Differential etiology is ‘a process that identifies a list of external agents . . . that potentially caused the disease.’”). Deborah Tuerkheimer’s *Flawed Convictions* contains an excellent analysis of this distinction. See DEBORAH TUERKHEIMER, *FLAWED CONVICTIONS: “SHAKEN BABY SYNDROME” AND THE INERTIA OF INJUSTICE* 75-82 (2014).

²²³ Ronald E. Gots, *Differential Diagnosis Versus Causation Assessment: Why They Are Separate Methodologies and How They Relate To Daubert*, INT’L CTR. FOR TOXICOLOGY & MED. (last visited Nov. 11, 2021 at 12:15 PM) https://irp-cdn.multiscreensite.com/562d25c6/files/uploaded/Gots_Differential-Diagnosis-versus-Causation-Assessment_Why-They-are-Separate-Methodologies-and-How-They-Relate-to-Daubert_2004_naysayer.pdf.

²²⁴ *Id.* at 1.

²²⁵ *McClain v. Metabolife Int’l, Inc.*, 401 F.3d 1233, 1252 (11th Cir. 2005) (quoting Mary Sue Henifin et al., *Reference Guide on Medical Testimony*, in REFERENCE MANUAL ON SCIENTIFIC EVIDENCE 439, 481 (2d ed. 2000)).

²²⁶ *Consaul*, 332 P.3d at 863 (quoting *Parkhill v. Alderman-Cave Milling & Grain Co.*, 245 P.3d 585, 590 (N.M. Ct. App. 2010)).

²²⁷ As one district judge put it, when it comes to doctors’ determinations, “[t]he differential diagnosis method has an inherent reliability; the differential etiology method does not.” *Bowers*, 537 F. Supp. 2d at 1361.

injury by establishing factors that may have served as the “but for” cause of these conditions.²²⁸

Yet the type of causal determination involved in the third MCA inquiry—whether the parent “instigated” the medical care—turns on a value judgment rather than a factual judgment about cause that is within the province of medical knowledge. This is because virtually all of children’s medical care is “instigated” by parents in the “but-for cause” sense, since parents almost always take children for medical care. CAPs, though, do not identify all such conduct as MCA; instead, they read the term “instigate” to apply only to those parents whom they believe have done something sufficiently improper to rise to the level of “medical child abuse.”²²⁹ Yet the blameworthiness of the parent’s conduct is properly a matter for the court to assess based on legal principles, not for the medical expert. Further, the physicians’ medical expertise gives him/her insight about the child’s bodily processes; it does not contribute any special insight into parent’s blameworthiness. Rule 702’s “helpfulness” standard, which requires a valid scientific connection to the pertinent inquiry as a precondition to admissibility is therefore not met here.²³⁰

The American Law Institute agrees that the so-called “diagnosis” of MCA exceeds the proper scope of expert medical testimony. Its *Restatement of Children and the Law*, now in draft form, declares that “[i]n cases in which . . . allegations of physical abuse involve a parent’s seeking unnecessary medical treatment for a child, whether the parent’s actions constitute physical abuse

²²⁸ See *Black v. Food Lion, Inc.*, 171 F.3d 308, 314 (5th Cir.1999). For example, in the case of *Bowers v. Norfolk S. Corp.*, 537 F. Supp. 2d at 1360, the medical expert sought to testify to whether a train’s vibrations were the cause of the plaintiff’s back and neck pain, meaning whether the plaintiff would have experienced the pain absent the railroad’s vibrations. *Id* at 1345. That judgment reflected a simple factual determination regarding whether vibrations can produce certain conditions that involve pain.

²²⁹ As Roesler and Jenny framed the issue, the question about the parent’s actions at this stage is whether “the harm or potential harm to the child [is] sufficient to warrant consideration for protection?” ROESLER & JENNY, *supra* note 31, at 141.

²³⁰ FED. R. EVID. 702.

is a determination to be made by the factfinder.”²³¹ The Reporter’s Comments expand on this issue further, declaring that

[c]ourts should not admit expert medical testimony regarding the medical child abuse diagnosis. As Comment *k* explains, expert testimony regarding diagnoses properly pertains to the child’s bodily conditions. In contrast to traditional medical diagnoses, the determination of medical child abuse is not centered on assessing an underlying bodily condition, but instead represents a determination that the parent’s actions in obtaining medical care for a child should be considered physical abuse.²³²

The *Restatement* therefore limits expert medical testimony in abuse proceedings to “factual issues underlying the ultimate legal issue of physical abuse,” including “diagnos[ing] the child’s medical conditions, . . . as well as the medical consequences of those conditions for the child.”²³³

b. *The medical child abuse determination and the ultimate issue in a child abuse case*

Testimony that the child was a victim of “medical child abuse” is also inadmissible because it is the ultimate issue in child abuse proceedings. Federal Rule of Evidence 704, which states that “[a]n opinion is not objectionable just because it embraces an ultimate issue,” at first blush might seem to permit this testimony.²³⁴ Yet courts have made clear that this rule “does not open the door to all opinions. . . . [Q]uestions which would merely allow the witness to tell the jury what result to reach are not permitted. Nor is the rule intended to allow a witness to give legal conclusions.”²³⁵ On this basis, courts allow experts to testify

²³¹ RESTATEMENT OF THE LAW – CHILDREN AND THE LAW, *supra* note 200, at § 3.20 comment *k*.

²³² *Id.* at reporter’s note comment *k*.

²³³ *Id.*

²³⁴ FED. R. EVID. 704.

²³⁵ *Owen v. Kerr-McGee Corp.*, 698 F.2d 236, 240 (5th Cir. 1983); *see also* *United States v. Perkins*, 470 F.3d 150, 159 (4th Cir. 2006) (expert opinion must be “helpful[] to the jury,” and therefore state some information other than a legal conclusion); *Monroe v. Griffin*, No. 14-CV-00795, 2015 WL 5258115, at *6 (N.D. Cal. Sept. 9, 2015) (noting that an expert opinion is not objectionable just because it embraces an ultimate issue; “[h]owever, an expert witness cannot give an opinion as to her legal conclusion, i.e., an opinion on an ultimate issue of law” (quoting *Elsayed Mukhtar v. Cal. State Univ., Hayward*, 299 F.3d 1053, 1065-66 n.10 (9th Cir. 2002))).

to factual issues underlying the ultimate issue, but preclude testimony on the ultimate legal issue itself.²³⁶ For example, in *Young v. State Farm Mutual Automobile Ins. Co.*,²³⁷ the plaintiff, who sued his insurer to establish that his daughter's injuries were covered, sought to introduce an expert to testify that "in his opinion [plaintiff's daughter] was covered under the automobile insurance policy."²³⁸ The court rejected this testimony on the ground that it presented "nothing more than a legal conclusion as to the ultimate issue in the case."²³⁹

An expert's use of legal language such as "medical child abuse" is a red flag on this issue. Carole Jenny and Thomas Roesler noted when coining the term "medical child abuse" that it was meant to convey that the parent has committed child abuse.²⁴⁰ Yet courts have repeatedly held that "expert witnesses' use of 'judicially defined terms,' 'terms that derived their definitions from judicial interpretations,' and 'legally specialized terms' . . . constitute [an] expression of opinion as to the ultimate legal conclusion."²⁴¹ For this reason, an expert's testimony in a police excessive force suit that an officer had used "grossly unlawful, unnecessary, and excessive violence," was deemed impermissible.²⁴² In the court's words, an expert must avoid use of

²³⁶ See FED. R. EVID. 704 Notes of Advisory Committee on Proposed Rule ("Did T have capacity to make a will?" impermissibly asks for a legal conclusion, while the question "Did T have sufficient mental capacity to know the nature and extent of his property?" does not).

²³⁷ *Young v. State Farm Mut. Auto. Ins. Co.*, No. 2:97- CV-24-B-B, 1999 WL 33537177, at *2 (N.D. Miss. Feb. 16, 1999).

²³⁸ *Id.*

²³⁹ *Id.*

²⁴⁰ See *supra* note 39.

²⁴¹ *In re ConAgra Foods, Inc.*, 302 F.R.D. 537, 558 (C.D. Cal. Aug. 1, 2014) (quoting *Wiles v. Department of Educ.*, Civ. Nos. 04-00442 ACK-BMK, 05-00247 ACK-BMK, 2008 WL 4225846, *1 (D. Haw. Sept. 11, 2008)) (declaring improper an expert's opinion that ConAgra "'falsely and deceptively labeled' its products" since "false" and "deceptive" are judicially defined terms relating to the ultimate issue in this case); see also *S.E.C. v. Leslie*, No. C 07-3444, 2010 WL 2991038, at *9 (N.D. Cal. July 29, 2010) (excluding expert's opinion because "it is for the jury to determine whether Defendants' statements in fact were misleading").

²⁴² *Monroe v. Griffin*, No. 14-CV-00795-WHO, 2015 WL 5258115, at *7 (N.D. Cal. Sept. 9, 2015); see also *Estate of Bojic v. City of San Jose*, No. C05 3877 RS, 2007 WL 3314008, at *3 (N.D. Cal. Nov. 6, 2007) ("[W]hile [the plaintiff's expert] may freely opine that [the officer] should not have acted in the

“language that constitutes legal conclusions, credibility determinations, or otherwise ‘merely tell[s] the jury what result to reach.’”²⁴³ As the Advisory Committee to Federal Rule of Evidence 704 noted, it is particularly important to “exclude opinions phrased in terms of inadequately explored legal criteria.”²⁴⁴ The importance of excluding such opinions is heightened in the case of MCA testimony because, as Part III noted, such opinion use the legal term “child abuse,” but apply incorrect legal criteria to determine whether it occurred.

Accordingly, in cases in which child abuse through medical care is alleged, assuming their testimony meets the requirements for scientific reliability (which the next section will discuss), doctors may properly testify to the first two determinations now rolled into the MCA analysis: (1) the genuine medical diagnoses that the child possesses; and (2) whether, given these diagnoses, the treatment the child received was excessive. Yet they may not “diagnose” the child with MCA and, through this, assert that the parent committed abuse. Put another way, simply because doctors have concocted a new designation that allows them to designate their disapproval of virtually any medical care that a child receives and then improperly to call this designation a “diagnosis” and incorrectly claim that it demonstrates that parents have committed child abuse, does not mean that they should be permitted to undermine a parent’s fair trial by testifying in court to its presence.

3. *The medical child abuse “diagnosis” and scientific reliability*

Counsel for the parents should also seek to bar admission of expert testimony regarding the MCA “diagnosis” on the ground that the methodology used to make this determination is both unscientific and unreliable. As the U.S. Supreme Court made clear in *Daubert v. Merrell Dow Pharmaceuticals*, with state courts following suit, the trial judge must act as a gatekeeper to

manner that he did, or that he should have done something else, he should not be asked for or volunteer an opinion that [the officer] acted unconstitutionally or exercised ‘excessive force.’”

²⁴³ *Monroe*, 2015 WL 5258115, at *7 (quoting FED. R. EVID. 904, Advisory Committee Notes to 1972 Proposed Rules).

²⁴⁴ FED. R. EVID. 704 Notes of Advisory Committee on Proposed Rules.

“ensure that any and all scientific testimony or evidence admitted is not only relevant, but reliable.”²⁴⁵ The burden of establishing that expert testimony is scientifically sound “rests on the proponent of the expert opinion.”²⁴⁶ Establishing reliability “requires more than simply ‘taking the expert’s word for it.’”²⁴⁷ In evaluating admissibility, the court must assess both “whether the reasoning or methodology underlying the [expert’s] testimony is scientifically valid,” and “whether that reasoning or methodology properly can be applied to the facts in issue.”²⁴⁸

Courts acting as gatekeepers require proof of the scientific validity of both the “general” and “specific” medical hypotheses that physicians offer. Proof of the general medical hypothesis requires a showing that the disease or agent claimed responsible for causation can cause the kind of signs and symptoms that the patient has shown *in at least some people*.²⁴⁹ Meanwhile, proof of the specific medical hypothesis requires a showing that the disease or agent claimed to cause the condition is responsible for the signs and symptoms *in the specific patient*. For example, a medical expert testifying that the patient’s acute back pain was caused by a train’s vibrations must be able to prove scientifically that train vibrations are capable of causing acute back pain *in some people* (the general causation question), as well as defend the validity of the determination that *this patient’s* back pain was caused by train vibrations (the specific causation question).²⁵⁰

²⁴⁵ *Daubert*, 509 U.S. at 590.

²⁴⁶ *United States v. Frazier*, 387 F.3d 1244, 1260 (11th Cir. 2004).

²⁴⁷ FED. R. EVID. 702 advisory committee’s note (2000); *see also* *Gen. Elec. Co. v. Joiner*, 522 U.S. 136, 137 (1997) (“[N]othing in either *Daubert* or the Federal Rules of Evidence requires a district court to admit opinion evidence that is connected to existing data only by the *ipse dixit* of the expert.”).

²⁴⁸ *Daubert*, 509 U.S. at 592–93.

²⁴⁹ *McClain*, 401 F.3d at 1242; *Clausen v. M/V New Carissa*, 339 F.3d 1049, 1057–58 (9th Cir. 2003) (“The issue . . . is which of the competing causes are *generally* capable of causing the patient’s symptoms or mortality.”); *Moore v. Ashland Chem. Inc.*, 151 F.3d 269, 278 (5th Cir. 1998) (excluding expert testimony which “offered no scientific support for his general theory that exposure to Toluene solution at any level would cause RADS”).

²⁵⁰ *See Doe v. Ortho-Clinical Diagnostics, Inc.*, 440 F. Supp. 2d 465, 471 (M.D.N.C. 2006) (“General causation ‘is established by demonstrating . . . that exposure to a substance can cause a particular disease. . . . Specific, ‘or individual causation, however[,] is established by demonstrating that a given exposure is the cause’ of a particular individual’s disease.”).

As described in the next subsections, expert diagnoses of MCA fail to meet the bar of scientific reliability both for general and specific causation. Subsection a. shows that the general theory underlying MCA is not grounded in the methods of science because it has no testable hypothesis, and instead turns on an unscientific assessment regarding the parent's blameworthiness. Subsection b. demonstrates that the reliability of the process for determining MCA in particular cases has never been tested and, therefore, has an unknown but likely high error rate. Further, the process CAPs use to identify MCA cannot accurately distinguish between loving parents legitimately seeking care for sick children and genuine child abusers.

a. *The general medical child abuse theory*

The general theory of MCA fails the test for scientific validity because no testable scientific proposition underlies it. As *Daubert* makes clear,

a key question to be answered in determining whether a theory or technique is scientific knowledge that will assist the trier of fact is whether it can be (and has been) tested . . . [G]enerating hypotheses and testing them to see if they can be falsified . . . is what distinguishes science from other fields of human inquiry.²⁵¹

As described in the Advisory Committee Notes to Rule 702, the “testability” of a theory refers to “whether the expert’s theory can be challenged in some objective sense, or whether it is instead simply a subjective, conclusory approach that cannot be reasonably assessed for reliability.”²⁵² The general theory that underlies MCA fails this standard because it is nonfalsifiable.

To explain: Usually, the general hypothesis that underlies a medical diagnosis postulates that a particular biological process or disease produces a certain constellation of symptoms. Such a hypothesis is scientific because it can be disconfirmed based on observational or experimental evidence. As stated by Karl Popper, the philosopher of science cited in *Daubert*, “[S]tatements or systems of statements, in order to be ranked as scientific, must be capable of conflicting with possible, or conceivable, observa-

²⁵¹ *Daubert*, 509 U.S. at 593 (citing Michael Green, *Expert Witnesses and Sufficiency of Evidence in Toxic Substances Litigation: The Legacy of Agent Orange and Bendectin Litigation*, 86 Nw. U. L. REV. 643, 645 (1992)).

²⁵² FED. R. EVID. 702 advisory committee’s note (2000),

tions.”²⁵³ Genuine medical diagnoses can be tested. For example, the flu is a medical diagnosis that postulates that a particular set of viruses cause a particular set of symptoms in humans that include fever, achiness, and lack of energy. This general medical hypothesis is potentially testable and falsifiable through, for example, experiments that investigate whether any such viruses can be isolated among a group of patients with these symptoms. To take another example, the theory underlying the controversial diagnosis of chronic Lyme disease is that Lyme disease remains in the body of patients for long periods of time and causes a long-term cluster of symptoms that include fatigue, pain, and decreased short-term memory.²⁵⁴ This hypothesis is subject to testing, which can support or contradict the hypothesis. For example, researchers tested the genetic “fingerprint” of the bacteria in the blood of patients with a resurgence of active Lyme disease to determine if it matches the old Lyme bacteria; the finding that these two “fingerprints” do not match weighs against the hypothesis that chronic Lyme disease remains in the body and is the cause of the resurgence of Lyme symptoms.²⁵⁵

The general theory of MCA rests on no such testable scientific hypothesis. Its proponents’ description of this “diagnosis” as a “child [who] receives unnecessary and harmful or potentially harmful medical care at the instigation of a caretaker,”²⁵⁶ does not produce a testable hypothesis regarding an underlying disease process or other underlying cause that is responsible for the MCA symptoms. Indeed, it is difficult to conceptualize what evidence would be sufficient to disprove it.²⁵⁷ Unlike strep, there is

²⁵³ KARL R. POPPER, *CONJECTURES AND REFUTATIONS: THE GROWTH OF SCIENTIFIC KNOWLEDGE* 51 (2d ed. 2002); *see also* S.V. v. R.V., 933 S.W.2d 1, 26 (Tex. 1996) (Gonzalez, J., concurring) (“The key question in determining whether a theory or technique can be classified as science is whether it can be tested empirically.”).

²⁵⁴ Denise Grady, *New Infection, Not Relapse, Brings Back Lyme Symptoms, Study Says*, N.Y. TIMES, (Nov. 14, 2012), <https://www.nytimes.com/2012/11/15/health/new-infection-not-relapse-brings-back-symptoms-of-lyme-disease-study-finds.html>.

²⁵⁵ *Id.*

²⁵⁶ *See* ROESLER & JENNY, *supra* note 31, at 43.

²⁵⁷ *See* Nancy Levit, *Listening to Tribal Legends: An Essay on Law and the Scientific Method*, 58 FORDHAM L. REV. 263, 271 (1989) (“If theories are non-falsifiable, they are unscientific.”).

no swab of a child's body that can be tested in a lab; unlike cancer, it cannot be seen in a scan; unlike Lyme disease, there are no blood tests to disprove or refine the theory. While MCA's progenitor, the MSBP diagnosis, was deeply flawed, it at least rested on a testable hypothesis—that a particular psychological disorder in the parent was causing the parent's behavior. That hypothesis could be tested through, for example, psychological testing to show whether parents who committed such behavior had particular psychological abnormalities. But in rejecting considering the parent's psychology and simply focusing on a parent's "instigating" overtreatment of the child, MCA has moved to an untestable theory.

It could be argued that the hypothesis that underlies the MCA diagnosis is that parents' instigation of medical care causes MCA in much the same way that a virus causes the flu. Yet, if the term "instigation" is read as simply a factual description of parents' actions, similar to the but-for cause test for causation, the hypothesis is essentially tautological: given that almost all medical care received by children is instigated by a parent, this tells us nothing meaningful about medical child abuse that, for example, would let us distinguish children who are the victims of medical malpractice from children who are the victims of Munchausen-type behavior. This reading of MCA is equivalent to postulating that lungs are the cause of the cluster of symptoms associated with lung cancer: Of course, lungs are the necessary precondition to having those symptoms, but positing lungs as the problem tells us nothing useful about what has gone awry with this condition. In the alternative, to the extent that the term "instigate" is interpreted in a manner that incorporates some judgment that the parent's seeking medical care is blameworthy, the determination is not an empirical determination within the province of science, but a normative inquiry properly within the province of the court.²⁵⁸ The postulate regarding strep can ultimately be empirically supported or disconfirmed. In contrast, the postulate regarding a parent's role in MCA involves a value judgment

²⁵⁸ See FED. R. EVID. 702 advisory committee's note to 2000 amendment (stating that the court is required to consider whether the expert's theory can be tested or challenged by objective means or whether, instead, it is based simply upon the subjective, conclusory assertions of the expert).

regarding moral responsibility that is not testable or falsifiable in the same way.

MCA proponents may therefore certainly argue to a state legislature that the broad group of parental behaviors this conceptualization would include should all, as a matter of public policy, be considered abuse. However, they may not make such assertions as expert witnesses in court based on their claimed scientific expertise. Allowing expert testimony regarding MCA gives it the misleading appearance of a true medical diagnosis like polio or breast cancer. This cloaks the medical expert's own unscientific opinion about the blameworthiness of the parent's actions under a veneer of scientific respectability and reliability.

In seeking to present an expert's subjective opinion in the guise of a scientific diagnosis, MCA bears similarity to the discredited "diagnosis" of "Parental Alienation Syndrome" (PAS). That "diagnosis" was concocted in the 1980s by mental-health experts testifying for fathers in custody cases. These experts claimed to identify a constellation of symptoms in children that resulted from the mother's attempts to "brainwash" them to dislike their fathers. However, an increasing number of courts have deemed PAS inadmissible as junk science on several grounds.²⁵⁹

²⁵⁹ See *Hanson*, 685 N.E.2d at 85 ("Dr. Garner's PAS 'disorder' is a disturbing, inflammatory, unscientific and unsubstantiated theory which has no place in our courtrooms."); *Snyder*, 2006 WL 539130, at *8 ("There is insufficient evidence that the description . . . of 'parental alienation syndrome' has any scientific basis."); *Mastrengelo v. Mastrengelo*, No. NNHFA054012782S, 2012 WL 6901161, at *9 (Conn. Super. Ct. Dec. 20, 2012) ("the proffer of Dr. Baker's testimony regarding the concept of 'parental alienation syndrome' does not meet the relevant standards . . . , and is therefore inadmissible"); *Gillespie v. Gillespie*, No. 1849, 2016 WL 1622890, at *12 (Md. Ct. Spec. App. Apr. 25, 2016) (Friedman, J., concurring) ("I would caution courts, lawyers, expert witnesses, and litigants not to use the terms 'parental alienation' or 'parental alienation syndrome' casually, informally, or as if they have a medically or psychologically diagnostic meaning that has not been established."); *NK v. MK*, No. XX07, 2007 WL 3244980, at *64 (N.Y. App. Div. Oct. 1, 2007) ("This court does not believe that there is a generally accepted diagnostic determination or syndrome known as 'parental alienation syndrome.'"). See generally Carol S. Bruch, *Parental Alienation Syndrome and Parental Alienation: Getting It Wrong in Child Custody Cases*, 35 FAM. L.Q. 527, 539 (2001) (quoting Dr. Paul J. Fink, past president of the American Psychiatric Association: "PAS as a scientific theory has been excoriated by legitimate researchers across the nation. Judged solely on [its] merits, [PAS] should be a rather pathetic footnote or an example of poor scientific standards.").

First, PAS was conceptualized by doctors seeking to treat a child's condition therapeutically; instead, both were framed to put a pejorative spin in court on a parent's actions. As one commentator put it, framing these doctors' views as a diagnosis "sounds more impressive coming from the lips of a testifying mental health professional than 'She's just a lying, angry woman.'"²⁶⁰ Second, PAS was never subjected to rigorous empirical research or testing either then or since.²⁶¹ Third, although the real target of the PAS diagnosis is the parent, experts invented a diagnosis for the child.²⁶² Indeed, as with MCA, the charging expert in a PAS case has often never examined the child, let alone the parent.²⁶³ Judges should exclude MCA for the same reasons.

b. *The process of making MCA determinations*

Even if the general theory of MCA were scientific, to admit an MCA diagnosis in a particular case, the government would still have to demonstrate that the methodology applied in that case was reliable.²⁶⁴ A key factor in assessing the reliability of a determination made using a particular methodology is that meth-

²⁶⁰ Paula J. Caplan, *Parental Alienation Syndrome: "Another Alarming DSM-5 Proposal,"* PSYCHOL. TODAY (June 7, 2011), <https://www.psychologytoday.com/blog/science-isnt-golden/201106/parental-alienation-syndrome-another-alarming-dsm-5-proposal>.

²⁶¹ See *Snyder v. Cedar*, No. NNHCv010454296, 2006 WL 539130, at *8 (Conn. Super. Ct. Feb. 16, 2006) ("[T]here appears to be an absence of empirical research that reliably identifies a cause for the behavior of a pre-adolescent child who decides to reject contact with a parent. The prevailing opinion in the field, as Rotnem herself admitted when pressed, is that such empirical studies are unlikely ever to result in a reliable means of identifying such a 'syndrome' or its causes.").

²⁶² See, e.g., *Mastrengelo*, 2012 WL 6901161, at *9 ("[T]he analytical basis of, and one of the strongest objections to the scientific validity of, 'parent alienation syndrome' is that, rather than encompassing a review of the actions of the aligned parent, estranged parent *and* the child or children, the so-called syndrome focuses solely on the behaviors or actions of the child or children.").

²⁶³ See, e.g., *Snyder*, 2006 WL 539130, at *9 ("Rotnem testified that [the child] exhibited all of the classic characteristics of an "alienated child," notwithstanding that Rotnem had not . . . laid eyes on Aviva since [seven years before the asserted abuse]"); *Hanson v. Spolnik*, 685 N.E.2d 71, 85 (Ind. Ct. App. 1997) (Chezem, J., concurring) (noting that the expert making the PAS diagnosis interviewed neither mother nor child).

²⁶⁴ See *Magistrini v. One Hour Martinizing Dry Cleaning*, 180 F. Supp. 2d 584, 602 (D.N.J. 2002).

odology's "known or potential rate of error."²⁶⁵ Yet the government cannot show the reliability of the methodology used to "diagnose" MCA because it has never been tested for accuracy.²⁶⁶ This in itself should warrant exclusion of these diagnoses.²⁶⁷

Even leaving aside the absence of testing the MCA determination process for reliability, for an expert determination to be admissible, "it is critical that an expert's analysis be reliable at every step."²⁶⁸ This "means that *any* step that renders the analysis unreliable under the *Daubert* factors renders the expert's testimony inadmissible."²⁶⁹ Yet, as the discussion in Part III showed, all three standards used to identify MCA are likely to produce "false-positive" results. The failure to account for alternative innocent explanations for the positive results of each of these tests renders the entire MCA determination unreliable, and warrants its exclusion.²⁷⁰

²⁶⁵ *Daubert*, 509 U.S. at 594.

²⁶⁶ See *supra* notes 58-61, 174-177 and accompanying text.

²⁶⁷ *Frank v. State of New York*, 972 F. Supp. 130, 135 (N.D.N.Y. 1997). (excluding Multiple Chemical Sensitivity diagnosis in part based on "the lack of an objective testing method for MCS[, which] gives rise to high probability of error in MCS diagnoses. . . . [P]laintiffs have submitted no proof of any testing rate for MCS, much less a reliable one."); *State v. Walters*, 698 A.2d 1244, 1247 (N.H. 1997) (refusing to admit repressed memories on the ground that "it would be impossible, ethically, to test repression and recovery of memory of severely traumatic events in a laboratory setting," and because there "was no real way to track the percentage or number of recovered memories that are 'false'").

²⁶⁸ *Amorgianos v. Amtrak*, 303 F.3d 256, 267 (2d Cir. 2002).

²⁶⁹ *In re Paoli*, 35 F.3d at 745; see also *In re Zolof*, 858 F.3d at 797 (3d Cir. 2017)

²⁷⁰ See *General Electric Company v. Joiner*, 522 U.S. 136, 139-40 (1997) (excluding expert testimony for failure to exclude alternative explanations for subjects' symptoms); *In re Paoli*, 35 F.3d at 757 (excluding expert opinion that failed to consider alternative causes of the plaintiff's bruising); *Perry*, 564 F. Supp. 2d at 471 (excluding expert testimony that defendant's drug caused cancer because expert "fail[ed] to adequately account for the possibility that [defendant's cancer] was idiopathic"); see also Fed. R. Evid. 702 advisory committee's note to 2000 amendment ("[O]ther factors relevant in determining whether expert testimony is sufficiently reliable to be considered by the trier of fact . . . include . . . [w]hether the expert has adequately accounted for obvious alternative explanations.").

Conclusion

The right that our constitutional system grants parents to make decisions about their children's healthcare—a right premised on the recognition that parents are generally better situated than any other decisionmaker to understand and pursue their children's best interests—is being jeopardized by physicians too certain they know what is best for other people's children. These doctors are relying on the vague language of abuse statutes and wielding the fake medical diagnosis of MCA to persuade judges to ride roughshod over parents' constitutional rights. The result is that loving families of children with rare or complex medical conditions are being traumatized by abuse charges rather than able to get their children the medical care that is their constitutional right. Restoring parents' decision-making rights will take vigorous action from legislatures and attorneys representing parents to ensure that, in the future, abuse proceedings “hold in check, not release, the rescue fantasies” of the physicians they are now empowering to intrude.²⁷¹

²⁷¹ See Goldstein, *supra* note 3, at 651 (“Legislatures must be made to see that the requisite of parental consent to medical care for children becomes meaningless if refusal to consent automatically triggers state inquiry or a finding of neglect. State statutes then must be revised to hold in check, not release, the rescue fantasies of those it empowers to intrude, and thus to safeguard families from state-sponsored interruptions of ongoing family relationships by well-intentioned people who ‘know’ what is ‘best’ and who wish to impose their personal health-care preferences on others.”).